# Application for Limited Professional Liability Coverage Insured Paramedical Employee



Pro	ProAssurance Indemnity Company, Inc. • PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040					
Re	quested Effective Date://					
Na	me (Last, First, MI):					
SSI	N:	DOB:		Sex: Male 🗌 Female 🗀		
Но	me Address:	City:	State:	ZIP:		
Cui	rrent Employer:	Tele	ephone Number:			
Bus	siness Address:	City:	State:	ZIP:		
1.	Profession:					
	☐ Physician Assistant ☐ Surgical Assistant ☐ Certified Nurse Midwife	☐ Certified Nurse Practitioner ☐ Certified Registered Nurse Anesthetis ☐ Cytotechnologist	st			
2.	Is your employer insured by a ProAssurance Com	Yes 🗌 No 🔲				
3.	<ul> <li>Have you ever:</li> <li>A. Been convicted of a criminal offense?</li> <li>B. Been treated for (or recommended for treatrent)</li> <li>C. Undergone psychiatric treatment?</li> <li>D. Had a complaint filed against you with any had a complaint filed against you with any had any professional license/permit or narcon placed under probation?</li> <li>If the answer to 3.A., 3.B., 3.C., 3.D., or 3.E. in the properties of the properties of</li></ul>	Yes				
5.	Do you have your own separate practice without a collaborating physician?			Yes 🗌 No 🗍		
6.	Do you hold the certification of licensure required in your state to practice your profession? If yes, where did you receive your training?			Yes No No		
7.	Are you a member of any professional organization? If yes, please give details.			_		
8.	Have any judgments ever been rendered against y behalf from an incident alleging professional error If yes, please give details on a separate sheet. If av	rs or omissions?		ur Yes 🗌 No 🗍		

9.	Has any action been filed against you or have you be against you alleging professional errors or omissions.		y action, regardless	of dollar amount, will be filed	Yes 🗌 No 🗀	
	If yes, please give details on a separate sheet. If availa	able, please enclos	e copy of complaint			
10.	Has an insurance company that provided you medical professional liability or related coverage, including Lloyd's of London, ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? ( <i>This question is not applicable in Missouri.</i> )				Yes 🔲 No 🗀	
	If yes, please provide the reason(s) for the adverse un	nderwriting decisio	ons in the space pro	vided at the end of the application.		
11.	. Does your supervising physician regularly review medical records and cases with you?					
12.	Is your clinical competency validated by the physician?				Yes 🗌 No 🗀	
13.	. Will you be scheduled to work at a separate location from your supervising physician?			Yes 🗌 No 🗀		
	If yes, please give details on a separate sheet.					
14.	4. Does your practice comply in every way with the rules and regulations as set forth by the agency in your state charged with licensing and monitoring individuals in your profession?				Yes No	
15.	5. Do you elicit, record, and evaluate a health, psychosocial, and developmental history of the patient?				Yes 🗌 No 🗀	
16.	6. Do you order or perform diagnostic tests?				Yes 🗌 No 🗀	
17.	7. Do you discriminate between normal and abnormal findings on the history, physical, examination diagnostic tests, initiate referrals and consultations when needed?				Yes 🗌 No 🗀	
18.	Do you regulate or adjust medications and treatment	t as prescribed by o	or authorized by a li	censed physician?	Yes 🗌 No 🗀	
19.	Do you perform a physical examination?					
	If yes, briefly describe techniques and instruments us	sed:				
20.	Do you conduct informed consent discussions?				Yes 🗌 No 🗀	
21.	11. Describe any other procedures, treatments, or duties you perform:					
22	D				v□ N. □	
22.	Do you provide any cosmetic procedures/services? If yes, please indicate which procedures.				Yes No	
	Botox	Derma Filler	e e	Laser Hair Removal		
	Microdermabrasion	Laser Skin Re		Sclerotherapy		
23.	Do you perform Deliveries as a midwife?				Yes 🗌 No 🗀	
	If yes, please answer the following questions:					
	A. How many deliveries are performed annually by	midwife?				
	B. Do midwives perform induction/augmentation	?	Yes 🗌 No 🗌			
	C. Do Midwives perform assisted Vaginal Deliveri	es?	Yes 🗌 No 🔲			
	If yes, is the physician present?		Yes No			
	D. Do Midwives perform VBAC deliveries?		Yes No			
	If yes, is the physician present?		Yes No			
	E. Do Midwives perform underwater births?		Yes 🗌 No 🗍			
	F. Do Midwives perform home or birthing center	deliveries?	Yes No			
	•					
	G. As a mid-level provider do you follow alternativ  If yes, please describe:	~ .	Yes No			
24.	Describe your procedure for notifying your supervisi	ing physician of sit	cuations beyond the	scope of your training or practice:		
	-					

	State	License Number	Renewal Date	
. Ple	ase include copies of the following:			
. Ple	ase include copies of the following: Current Curriculum Vitae			
		n of supervision form		
Α.	Current Curriculum Vitae	-		
А. В.	Current Curriculum Vitae Copy of your approved notification	-		

# Texas and Virginia Purchasing Group Intent to Join

The undersigned insured hereby consents to join the Ob-Gyn Risk Alliance Purchasing Group, a purchasing group formed under the provision of the Liability Risk Retention Act of 1986. One of the purposes of this group is to purchase insurance on a group basis. ProAssurance Indemnity Company, Inc., with its home office located in Birmingham, Alabama, underwrites insurance policies issued for this group and may not be subject to all the rules and regulations of your state.

## Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application—regardless of whether or not I am granted insurance—and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

### Authorization to Release Information

I, the undersigned hereby authorize my present and prior professional liability carriers, any and all attorneys who have represented me in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding me, to release to ProAssurance upon its request, any information which in the judgment of any such person noted above, may have bearing upon my acceptability to ProAssurance as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

I hereby release and agree to hold harmless all persons or organizations, their agents, servants, and employees, ProAssurance, its directors, officers, employees and agents from any liability arising from releasing the above information, notwithstanding the fact that there may be errors, omissions or mistakes contained in such released information.

I further agree that ProAssurance and all persons and organizations described above may rely upon a photo copy of this Authorization, which shall be of equal validity with the signed original.

### Risk Management Agreement Language

I agree that my office staff and I will comply with all Ob-Gyn Risk Alliance risk management programs administered by ProAssurance companies. Our compliance includes cooperating with ProAssurance and its employees and independent contractors in all risk management assessments and recommendations, participating in educational programming, and committing to work with the Ob-Gyn Risk Alliance to improve patient care and thus reduce losses.

I agree to ensure that my staff will work to further such risk management collaboration and comply with all education and risk management improvement recommendations.

I understand that compliance with this statement is necessary for membership in the Ob-Gyn Risk Alliance Purchasing Group, and failure to comply may jeopardize further participation in the program.

Name (Printed):	
Applicant's Signature:	Date:
Note: ProAssurance's Privacy Policy can be found on ProAssurance.com.	
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Insured Physicia	an's Authorization
I hereby request the above applicant be added to my Policy as an Insured to underwriting approval.	Paramedical Employee. I understand that such coverage is subject
Requested Effective Date:	Shared Limits Coverage
	Separate Limits Coverage
	Note: Separate Limits Coverage is not available for Cytotechnologists.
Signature of Insured Physician/Supervising Physician	Date

Please Print Name