



**Medical Mutual**<sup>SM</sup>

PROTECTING OUR PROFESSION



**Notification to add Locum Tenens Physician:**

Name of MMIC Insured Physician for whom locum tenens physician will be working:

\_\_\_\_\_ Policy # \_\_\_\_\_

Name of Locum Tenens Physician: \_\_\_\_\_

NC Medical License Number: \_\_\_\_\_

Board Certified: Yes  No

If yes: Name of Certifying Board: \_\_\_\_\_

Dates Locum Tenens Physician worked in practice: \_\_\_\_\_

This notification must be received within 30 days of above dates in order for coverage to be effective.

\*\*\*Please have the physician for whom this locum tenens physician substituted read and sign below:

**Authorization by Substituted Insured Physician** – I hereby acknowledge and authorize Medical Mutual Insurance Company of NC to add the above named locum tenens physician to my coverage for the dates noted above. I understand that I have no professional liability coverage for any professional services I might render or fail to render on these dates, and that the named locum tenens physician will share in my Limits of Liability during such substitution. I further acknowledge that I am responsible for ensuring that the above-named physician is, to the best of my knowledge, competent, and that he/she possesses qualifications similar to my own.

\_\_\_\_\_  
Signature of Insured Physician

\_\_\_\_\_  
Date