

MEDICAL PRACTITIONERS PROFESSIONAL LIABILITY APPLICATION
Non-Assessable Claims-Made Coverage

(Please type or print in black ink.)

APPLICANT'S INSTRUCTIONS

- Please answer all questions completely and as they relate to the coverage being applied for.
- If space is insufficient to answer any questions fully, use the Additional Comments Section at the bottom of this form, or attach separate documentation.
- Are you applying for coverage in a "slot" position? Yes No If yes, please complete the application as they relate to the intended slot duties.
- Are you applying for coverage relating to vicarious liability for your employer? Yes No

Applicant

Full Name _____

Suffix Sr. Jr. I II III IV Professional Designation MD DO Gender Male Female

Social Security Number _____ Date of Birth ____/____/____

E-mail Address _____

Office Telephone (____) _____

Coverage

| | | |
|----------------|-----------------|-------------------------------|
| Practice State | Practice County | Desired Effective Date / / |
|----------------|-----------------|-------------------------------|

Desired Limits (Each Claim/Aggregate) Choose One Option

- | | | |
|--|--|---|
| <input type="checkbox"/> Same As Employer | <input type="checkbox"/> \$3,000,000/\$3,000,000 | <input type="checkbox"/> \$5,000,000/\$7,000,000 |
| <input type="checkbox"/> \$1,000,000/\$1,000,000 | <input type="checkbox"/> \$3,000,000/\$5,000,000 | <input type="checkbox"/> \$6,000,000/\$6,000,000 |
| <input type="checkbox"/> \$1,000,000/\$3,000,000 | <input type="checkbox"/> \$4,000,000/\$4,000,000 | <input type="checkbox"/> \$6,000,000/\$8,000,000 |
| <input type="checkbox"/> \$2,000,000/\$2,000,000 | <input type="checkbox"/> \$4,000,000/\$6,000,000 | <input type="checkbox"/> \$2,000,000/\$6,000,000 Available in Virginia only |
| <input type="checkbox"/> \$2,000,000/\$4,000,000 | <input type="checkbox"/> \$5,000,000/\$5,000,000 | |

Practice Locations

I practice at this location: Primary Practice Location

| | | |
|----------------|-------|----------------|
| Practice Name | | |
| Address Line 1 | | Address Line 2 |
| City | State | Zip Code |

List Other Locations at which you Practice

| | | |
|----------------|-------|----------------|
| Practice Name | | |
| Address Line 1 | | Address Line 2 |
| City | State | Zip Code |
| Practice Name | | |
| Address Line 1 | | Address Line 2 |
| City | State | Zip Code |
| Practice Name | | |
| Address Line 1 | | Address Line 2 |
| City | State | Zip Code |

Home Address

| | | | |
|---------------------------|-------|----------------|--|
| Address Line 1 | | Address Line 2 | |
| City | State | Zip Code | |
| Home Phone () | | | |

Prior Acts Coverage

Do you desire Prior Acts coverage? Yes No If Yes, Retroactive Date ____/____/____

If your current professional liability insurance is a claims-made policy, are you obtaining Extended Reporting (“tail”) coverage from your current insurance company? If no, please explain: Yes No

Prior Acts Coverage Certification

I request Prior Acts coverage retroactive to ____/____/____, which is consistent with the attached Declarations page from my current carrier.

I certify that I have no knowledge of any professional liability claims which have been asserted against this applicant, or any related professional corporation or professional association for which I am seeking coverage, which have not been reported to my prior or applicable carrier.

I further more certify that I have no knowledge of any occurrence, incident, or circumstance likely to result in such a claim as of this date, other than those reported on this application.

Notice of any such claim, incident, or circumstance should be given to your carrier if such notice has not already been provided. This policy will not provide coverage for any such claim, occurrence, incident, or circumstance.

I certify that the above is true, complete, and correct to the best of my knowledge, information, and belief. I understand that an incorrect or incomplete response could cause the denial of a claim or the cancellation of my protection if coverage is written as a result of this application.

Education

| Medical School | | State | From | To | Completed |
|----------------|-----------|-------|------|----|---|
| | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Residency 1 | Specialty | State | From | To | <input type="checkbox"/> Y <input type="checkbox"/> N |
| | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Residency 2 | Specialty | State | From | To | <input type="checkbox"/> Y <input type="checkbox"/> N |
| | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Fellowship | Specialty | State | From | To | <input type="checkbox"/> Y <input type="checkbox"/> N |
| | | | | | <input type="checkbox"/> Y <input type="checkbox"/> N |

Explain any gaps in your education history: _____

Practice History

| Name | City | State | From | To |
|------|------|-------|------|----|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Explain any gaps in your practice history: _____

Continuing Education

Number of hours of continuing education completed within the past two years _____

Medical License Information

| | State | License Number | Expiration Date | Status | % of Practice |
|---|-------|----------------|-----------------|---|---------------|
| 1 | | | / / | <input type="checkbox"/> Active <input type="checkbox"/> Inactive | |
| 2 | | | / / | <input type="checkbox"/> Active <input type="checkbox"/> Inactive | |
| 3 | | | / / | <input type="checkbox"/> Active <input type="checkbox"/> Inactive | |
| 4 | | | / / | <input type="checkbox"/> Active <input type="checkbox"/> Inactive | |
| 5 | | | / / | <input type="checkbox"/> Active <input type="checkbox"/> Inactive | |
| 6 | | | / / | <input type="checkbox"/> Active <input type="checkbox"/> Inactive | |

Board Certification Information

| Board Name | Certified | Expiration Date |
|------------|--|-----------------|
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | / / |
| | <input type="checkbox"/> Yes <input type="checkbox"/> No | / / |

If not Board Certified, explain what steps are being taken to obtain certification and expected completion date.

Please answer the following:

- Are you a graduate of a foreign medical school? Yes No
 If yes, are you certified by the Education Council for Foreign Medical Graduates (ECFMG)? Yes No
 Have you passed FLEX or USMLE? Yes No
 Name & location of Medical School: _____
- Has your medical or narcotics license ever been voluntarily or involuntarily withdrawn, suspended, denied, revoked, or restricted in any location? Yes No
 If yes, explain: _____
- Have you ever been or are you currently under a "consent order"? Yes No
 (If yes, please explain and attach a copy of consent order)
- Have you ever been diagnosed with, or treated for alcoholism, drug addiction, or mental or physical impairment? Yes No
 If yes, explain and provide dates and locations of all treatment or evaluations as well as names of your supervising and/or monitoring physicians. _____
- Have you ever been charged with any criminal activity? Yes No
 If yes, explain: _____
- Has any claim or suit for alleged sexual misconduct ever been brought against you? Yes No
 If yes, explain: _____
- Have you ever been questioned, investigated, or requested to appear before any of the following:
 - A state licensing board or equivalent? Yes No
 - A specialty or medical association? Yes No
 - A Medicare/Medicaid agency? Yes No
 - Other _____ Yes No
 If yes to any of the above, please explain: _____

Hospital Privileges

1. Do you have hospital privileges? Yes No
 If no, please explain:

If yes, list all of your current hospital privileges. (If "restricted" or "other," explain in the details section)

| | | |
|---|------|-------|
| Hospital Name | City | State |
| Type: <input type="checkbox"/> Pending <input type="checkbox"/> Full <input type="checkbox"/> Courtesy <input type="checkbox"/> Restricted <input type="checkbox"/> Other | | |
| Details: | | |
| Hospital Name | City | State |
| Type: <input type="checkbox"/> Pending <input type="checkbox"/> Full <input type="checkbox"/> Courtesy <input type="checkbox"/> Restricted <input type="checkbox"/> Other | | |
| Details: | | |
| Hospital Name | City | State |
| Type: <input type="checkbox"/> Pending <input type="checkbox"/> Full <input type="checkbox"/> Courtesy <input type="checkbox"/> Restricted <input type="checkbox"/> Other | | |
| Details: | | |

2. Have your hospital privileges ever been suspended, denied, revoked, restricted, or otherwise sanctioned? Yes No
 If yes, please explain:

Insurance History

Please list insurance information for the past ten (10) years or back to requested retroactive date, whichever is longer.

| | Current Carrier | 1st Prior Carrier | 2nd Prior Carrier | 3rd Prior Carrier | 4th Prior Carrier |
|--------------------------|---|---|---|---|---|
| Insurance Company | | | | | |
| Policy Number | | | | | |
| Coverage form | <input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence | <input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence | <input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence | <input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence | <input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence |
| Dates of Coverage | From: ___/___/___ To: ___/___/___ | From: ___/___/___ To: ___/___/___ | From: ___/___/___ To: ___/___/___ | From: ___/___/___ To: ___/___/___ | From: ___/___/___ To: ___/___/___ |
| Liability Limit | | | | | |
| Deductible | <input type="checkbox"/> No <input type="checkbox"/> Yes \$ | <input type="checkbox"/> No <input type="checkbox"/> Yes \$ | <input type="checkbox"/> No <input type="checkbox"/> Yes \$ | <input type="checkbox"/> No <input type="checkbox"/> Yes \$ | <input type="checkbox"/> No <input type="checkbox"/> Yes \$ |
| Retroactive Date | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ | ___/___/___ |

Insurance Questions

1. Has your professional liability insurance ever been surcharged, written with a deductible, or written in a non-standard market? If yes, explain: Yes No
2. Has your professional liability insurance ever been canceled, suspended, non-renewed, or declined: or have you ever voluntarily withdrawn your application for professional liability coverage? Yes No
 If yes, explain:
3. Have you previously had professional liability insurance provided by our company? Yes No

Medical Specialties

| Specialty | % of Practice | Specialty | % of Practice |
|--|---------------|--|---------------|
| <input type="checkbox"/> Aerospace Medicine | | <input type="checkbox"/> Occupational Medicine | |
| <input type="checkbox"/> Allergy and Immunology | | <input type="checkbox"/> Ophthalmology | |
| <input type="checkbox"/> Anatomic/Clinical Pathology | | <input type="checkbox"/> Orthopaedic Surgery | |
| <input type="checkbox"/> Anesthesiology | | <input type="checkbox"/> Otolaryngology | |
| <input type="checkbox"/> Clinical Biochemical Genetics | | <input type="checkbox"/> Pathology - Anatomic | |
| <input type="checkbox"/> Clinical Cytogenetics | | <input type="checkbox"/> Pathology - Clinical | |
| <input type="checkbox"/> Clinical Genetics (MD) | | <input type="checkbox"/> Pediatrics | |
| <input type="checkbox"/> Clinical Molecular Genetics | | <input type="checkbox"/> PhD Medical Genetics | |
| <input type="checkbox"/> Colon and Rectal Surgery | | <input type="checkbox"/> Physical Medicine and Rehab | |
| <input type="checkbox"/> Dermatology | | <input type="checkbox"/> Plastic Surgery | |
| <input type="checkbox"/> Diagnostic Radiology | | <input type="checkbox"/> Psychiatry | |
| <input type="checkbox"/> Emergency medicine | | | |
| <input type="checkbox"/> Family Medicine | | <input type="checkbox"/> Public Health & General Preventive Medicine | |
| <input type="checkbox"/> Internal Medicine | | <input type="checkbox"/> Radiation Oncology | |
| <input type="checkbox"/> Neurological Surgery | | <input type="checkbox"/> Radiologic Physics | |
| <input type="checkbox"/> Neurology | | <input type="checkbox"/> Surgery | |
| <input type="checkbox"/> Neurology w/special qualifications in child Neurology | | <input type="checkbox"/> Thoracic Surgery | |
| <input type="checkbox"/> Nuclear Medicine | | <input type="checkbox"/> Urology | |
| <input type="checkbox"/> Obstetrics and Gynecology | | <input type="checkbox"/> Vascular Surgery | |
| If you practice in a sub-specialty, please identify: | | | % |

If you practice any of the specialties below, please answer the applicable questions.

Anesthesiologists

Number of nurse anesthetists you employ: _____
 Number of nurse anesthetists you supervise at any given time: _____
 Are all nurse anesthetists certified? Yes No
 If **No**, please explain:

Do any of the nurse anesthetists employed or supervised by you administer anesthesia when you are not physically present on premises?
 Yes No

Do you conduct both a pre-anesthetic exam and a post-anesthetic follow-up? Yes No

General Surgeons

Do you do post-op follow ups or provide coverage for bariatric patients other than your own? Yes No
 Please explain:

Obstetricians and Gynecologists

Do you specialize in infertility and/or provide infertility treatment? Yes No
 If yes, please explain:

If you only practice Gynecology, did you ever practice Obstetrics? Yes No
 If yes, please explain, including date of last OB patient seen.

Radiologists

Do you perform invasive diagnostic procedures? Yes No
 If yes, please list _____

Do you practice as an **interventional radiologist**? Yes No
 If yes, please list procedures performed:

Does your practice include teleradiology?
If yes, please explain:

Yes No

Do you utilize "Nighthawk" type services?
If yes, please explain:

Yes No

Ophthalmologists

Indicate the percentage of your practice that is devoted to each of the following:

Cataract Removals _____ %
Reattachment of detached retinas _____ %
Removal of embedded foreign objects _____ %
Intra-ocular surgery _____ %

Corneal transplants _____ %
Eye muscle surgery _____ %
Vision Correction _____ %
List procedures: _____

Describe: _____

Please indicate any of the following procedures you currently perform in your practice requiring coverage under this policy:

Abortions

Number per month _____
% Elective _____
% Therapeutic _____

Acupuncture % of Practice _____

Anesthesia – Conscious Sedation Only

Anesthesia – General/Spinal

Anesthesia – Local Only Describe types: _____

Anesthesia – Nerve Block

Anesthesia – Pain Management

Explain procedures: _____

Assisting in Major Surgery Please specify:

My patients only Patients other than my own

Bariatrics

% Medical _____ % Surgical _____

Brachytherapy

Bronchoscopies

Cardiology Procedures

Right Heart Yes No

Diagnostic Cardiac Catheterization Yes No

Interventional Cardiology Yes No

Stent Placement Yes No

Coronary Angioplasty Yes No

Permanent Pacemaker Insertion Yes No

Electrophysiology Procedures Yes No

If **yes**, please list: _____

Other Interventional Procedures Yes No

If **yes**, please list: _____

Chelation Therapy Explain procedures: _____

Chemotherapy

Prescribing

Following Protocol Estab. By Oncologist

Brachytherapy

High Dose Rate

Circumcisions

Infants

Adults

Closed Reduction of Minor Fractures

Cryosurgery/Cryotherapy (Other than external lesions)

D & C

Electro-Convulsive Therapy

Endoscopic Procedures

Flexible Sigmoidoscopy

Colonoscopy

Endoscopy

ERCP

Upper GI/EGD

Other _____

Experimental Procedures Explain: _____

Homeopathy

Laparoscopic Procedures List: _____

Lithotripsy

Needle Biopsies Specify area: _____

Paracentesis/Thoracentesis

Prenatal/Obstetrical Care

Prenatal care only

* Gestational age of mother when transferred to care of an obstetrician? _____

Vaginal deliveries

C-Section deliveries

Non-Hospital based deliveries

Professional Sports Medicine Explain: _____

Radiation Therapy

Nuclear Medicine Yes No

Renal Dialysis

Spinal Punctures

Telemedicine Explain: _____

Vasectomies

***Please list any procedures you routinely perform not mentioned above:**

Cosmetic Procedures

Indicate if you or any of your staff perform the following:

| | Physician | Non-Physician Licensed Staff | Non-Licensed Staff |
|---|--------------------------|------------------------------|--------------------------|
| Botox Injection | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Chemical Peel | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Collagen Injection | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cosmetic Tattooing | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hair Transplants | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilite | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Laser Hair Removal | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Please specify type of procedure: <input type="checkbox"/> Ablative Laser <input type="checkbox"/> Non-ablative Laser | | | |
| Laser Wrinkle Remover | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Please specify type of procedure: <input type="checkbox"/> Ablative Laser <input type="checkbox"/> Non-ablative Laser | | | |
| Laser Pulse Therapy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Please specify type of procedure: <input type="checkbox"/> Ablative Laser <input type="checkbox"/> Non-ablative Laser | | | |
| Liposuction or other similar type of Procedure (e.g, Lipodissolve). | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Please specify type and area of body treated: | | | |
| Microdermabrasion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Permanent Make-up | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sclerotherapy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Please specify: | | | |

SURGICAL SPECIALTIES: If you are a surgeon, indicate the percentage of your surgical practice that is devoted to the following surgical activities:

Plastic Surgery _____ %
 - Reconstruction only _____ %
 - Cosmetic _____ %

*Please describe in detail any cosmetic surgery performed not mentioned above: _____

Bariatric Surgery _____ %

*Please describe the types of procedures performed: _____

Vascular Surgery _____ %
 Thoracic/Cardiac Surgery _____ %
 ENT _____ %
 Neurosurgery _____ %
 Obstetrical Surgery _____ %
 Gynecological Surgery _____ %
 Trauma Surgery _____ %
 Pediatric Surgery _____ %

Urological Surgery _____ %
 Orthopaedic Surgery _____ %
 Excluding Spine _____ %
 Including Spine _____ %
 Hand and/or Foot _____ %
 Ophthalmological Surgery _____ %
 General Surgery _____ %
 Dermatologic Surgery _____ %

Please answer the following:

1. Have you discontinued major surgical procedures? Yes No N/A
 If yes, list procedures and when last performed:

2. Has your medical specialty changed within the past 5 years? Yes No
 If yes, explain:

3. Do you moonlight at an Urgent Care Center, Trauma Center or ER in addition to your primary practice? Yes No
 % of practice _____ Hours per month _____
 Name of facility _____
4. Do you have any medically related duties that are insured by another company or for which you do not desire coverage by the company? Yes No
 If yes, explain: _____
5. Are you under contract to serve as a medical director in any capacity? Yes No
 If yes, explain: _____
6. Are you currently under contract or have plans to conduct clinical trials? Yes No
 If yes, explain: _____
7. Average number of patients treated weekly: _____
8. Average number of patients treated weekly by you in nursing homes: _____
 a. What percentage of these patients are not your regular patients? _____%
9. Do you provide medical services or prescribe medications via the internet and/or e-mail, including any type of "telemedicine"? If yes, explain: Yes No

- Does your practice utilize the services of any type of "nighthawk" service? If yes, explain: Yes No

10. Does your practice advertise? Yes No
 If yes, please provide copies of any written or web-based advertising materials you use to solicit patients for services.
11. Do you volunteer your medical services in any capacity? Yes No
 If yes, explain: _____
12. Who covers your night, weekend, and/or vacation call? _____
13. Do you dispense medications within your office? Yes No
 If yes, explain: _____
14. Are you using any Non-FDA approved devices? Yes No
 If yes, when and under what circumstances? _____
15. Do you prescribe Coumadin (Warfarin), or other anti-coagulant medications? Yes No
 If yes, answer the following questions:
 Do you have patient safety protocols in place for monitoring these patients? Yes No
 Do you utilize a specific informed consent for use of these medications? Yes No
16. Are you a member of an IPA, PHO, or MSO, etc.? Yes No
 If yes, please list all networks: _____

Part-time Practice

Part-time discounts are not available to physicians practicing in surgical specialties.

Do you practice medicine on a part-time basis? Yes No

What date did you begin your part-time practice? ____/____/____

Part-time situation:

- Semi-retired due to age
- Semi-retired due to health: Health condition: _____
- Practice full-time, but applying for partial coverage
 Activities for which coverage is not required under this policy. (Please attach a valid Certificate of Insurance evidencing coverage for these activities)
- Residency or Fellowship Program
- Military service or Federal Government agency
- Other: _____
 Program Name _____ Service/Agency _____ Please explain: _____
- Other part-time situation not described above
 Please explain, including name of employer and location: _____

Indicate the average number of hours per week of your part-time practice devoted to each of the following for which the company is to provide coverage:

Office Practice _____ Emergency Room _____ Hospital Practice _____
 Scheduled or rotating call _____ Other: (please describe) _____

Employment

I am a(n): Employee of a partnership/corporation Employee of an industrial organization Independent contractor
 Employee of a hospital or clinic Employee of a government agency Solo unincorporated
 Partner in a partnership or shareholder in a professional corporation or association
 Other: _____

Share or Lease Office Space

Do you share or lease office space? Yes No
 If yes, explain: _____

Solo Professional Corporation (PC)/Solo Professional Association (PA)

Do you have a Solo Professional Corporation (PC) or Solo Professional Association (PA)? Yes No

Solo PC or Solo PA will share in the physician's individual limit at no additional charge

Name of organization: _____

Date PA or PC was formed: ____/____/____

Have there been any settlements/judgments made on behalf of your PA or PC, or any claims Pending? *If yes, please complete the Claims History section of this application.* Yes No

Provide the number of non-physician personnel employed by you or your PA or PC

Nurses _____ Physical Therapists _____ Lab Techs _____
 CMA's _____ X-Ray Techs _____ Other _____

The following individuals are not automatically covered under our policy, and must apply individually for coverage.

| | Role | Individuals |
|---|------------------------------------|-------------|
| Physicians | <input type="checkbox"/> N/A | |
| | <input type="checkbox"/> Supervise | |
| | <input type="checkbox"/> Employ | |
| Physicians Assistant | <input type="checkbox"/> N/A | |
| | <input type="checkbox"/> Supervise | |
| | <input type="checkbox"/> Employ | |
| Nurse Practitioner | <input type="checkbox"/> N/A | |
| | <input type="checkbox"/> Supervise | |
| | <input type="checkbox"/> Employ | |
| CRNA | <input type="checkbox"/> N/A | |
| | <input type="checkbox"/> Supervise | |
| | <input type="checkbox"/> Employ | |
| Nurse Midwife | <input type="checkbox"/> N/A | |
| | <input type="checkbox"/> Supervise | |
| | <input type="checkbox"/> Employ | |
| Residents | <input type="checkbox"/> N/A | |
| | <input type="checkbox"/> Supervise | |
| | <input type="checkbox"/> Employ | |
| Psychotherapists | <input type="checkbox"/> N/A | |
| | <input type="checkbox"/> Supervise | |
| | <input type="checkbox"/> Employ | |
| Licensed Clinical Social Workers | <input type="checkbox"/> N/A | |
| | <input type="checkbox"/> Supervise | |
| | <input type="checkbox"/> Employ | |

Claims History

Attach current Loss Run (No more than 90 days old) for previous 10 years of practice. (A *loss run* is a document from your previous professional liability carrier(s) verifying claims, suits, or reported incidents). **Your application will not be processed without this information.**

- 1.) Have any claims or suits been brought against you, or have you reported any incidents concerning your professional services? Yes No
- 2.) Do you have knowledge of any circumstances involving the rendering or failure to render professional services that could result in a claim being brought against you? Yes No

If you answered **Yes** to #1 or #2 above, please complete the following for each such circumstance.
If you need more space, use comments section or attach additional sheet on back.

For paid claims, please attach a copy of the National Practitioner Data Bank Submission, if available.

| | | | |
|--|-------------------------------------|-----------------------|-------------------|
| Patient's Name | | | |
| Date of Occurrence | | Insurance Carrier | |
| Location of Occurrence | | | |
| Date claim reported ____/____/____ | Date claim closed ____/____/____ | Amount reserved \$ | Amount paid \$ |
| Full description of Allegation and Resolution: | | | |
| | | | |
| | | | |
| | | | |

| | | | |
|--|-------------------------------------|-----------------------|-------------------|
| Patient's Name | | | |
| Date of Occurrence | | Insurance Carrier | |
| Location of Occurrence | | | |
| Date claim reported ____/____/____ | Date claim closed ____/____/____ | Amount reserved \$ | Amount paid \$ |
| Full description of Allegation and Resolution: | | | |
| | | | |
| | | | |
| | | | |

| | | | |
|--|-------------------------------------|-----------------------|-------------------|
| Patient's Name | | | |
| Date of Occurrence | | Insurance Carrier | |
| Location of Occurrence | | | |
| Date claim reported ____/____/____ | Date claim closed ____/____/____ | Amount reserved \$ | Amount paid \$ |
| Full description of Allegation and Resolution: | | | |
| | | | |
| | | | |
| | | | |

