



PHYSICIAN EXTENDER PROFESSIONAL LIABILITY APPLICATION
Non-Assessable Claims-Made Coverage

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 back of this form, or attach separate documentation.
- Are you applying for coverage relating to vicarious liability for your employer? Yes No

Applicant

Full Name _____

Suffix Sr. Jr. I II III IV V Gender Male Female

Professional Designation CNM CRNA DPM LPN NP OD
 OT PA Pharm PhD PT RN

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

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
Continue locations on next page. . .		

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 ____/____/____

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.

Applying for coverage as:

Designation: Nurse Midwife Nurse Anesthetist (CRNA) Nurse Practitioner
 Physician Assistant Other: _____

License Number: _____

Professional/Clinical Education

Institution	State	
From ____/____/____	To ____/____/____	Date of Graduation ____/____/____
Diploma/Certification received:		

Institution	State	
From ____/____/____	To ____/____/____	Date of Graduation ____/____/____
Diploma/Certification received:		

Do you belong to any national organizations?

Yes No

If yes, please specify:

Professional/Clinical Experience

Employer (Most recent)	State	From ____/____/____	To ____/____/____
Employer (Prior Experience)	State	From ____/____/____	To ____/____/____
Employer (Prior Experience)	State	From ____/____/____	To ____/____/____

Explain any gaps in time in your Medical Education/Training and Practice History:

Coverage Information

How many hours will you work per week, on average with this employer? _____

Do you work outside the employment of this employing physician or group?

Yes No

If yes, please explain, including name of employer, type of work, and hours:

Are you presently covered as an individual insured on another professional liability insurance policy?

Yes No

If yes, will that policy continue in force?

Yes No

Please explain:

**Please submit a Certificate of Insurance to verify coverage.*

Insurance History

	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	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____

Please answer the following:

1. Has your medical or narcotics license ever been voluntarily or involuntarily withdrawn, suspended, denied, revoked, or restricted in any location? If yes, please explain: Yes No

2. Has your professional liability carrier ever canceled or non-renewed your coverage or surcharged your premium? If yes, please explain: Yes No

3. Have you ever been or are you currently under a "consent order"? Yes No
If yes, please attach a copy.

4. Have you ever been diagnosed with, or treated for, alcoholism, drug addiction, or mental or physical impairment? Yes No
If yes, please explain and provide dates and location of all treatment or evaluations as well as names of your supervising and/or monitoring physicians.

5. Have you ever been charged with any criminal activity? If yes, please explain: Yes No

6. Has any claim or suit for alleged sexual misconduct ever been brought against you? If yes, please explain: Yes No

7. Have your hospital privileges ever been denied, restricted, suspended, revoked, or voluntarily surrendered within the past 3 years? Yes No
If yes, please explain:

8. Have you ever been questioned, investigated, or requested to appear before any of the following: Yes No
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:

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

Physician Assistant (PA) or Nurse Practitioner (NP)

- a) Have you been approved to work at this site and is your employer (employing physician) listed as your supervisor or back-up supervisor by the Board? Yes No

(COVERAGE CANNOT BE ISSUED WITHOUT SITE AND SUPERVISOR APPROVAL FROM THE BOARD)

If not approved, what is the status of your approval? Please explain, including name and address of intended supervising physician:

If approved, give name and address of supervising physician:

- b) Check the sites where you will perform your duties:

Office w/ supervising physician always present Office w/ supervising physician occasionally present
 Hospital Emergency Room

- c) Are the required written documents in place and accessible outlining your supervising physician's availability for consultation, collaboration, and evaluation of your medical acts? Yes No

Nurse Midwife

- a) Have you been approved to work at this site and is your employer (employing physician) listed as your supervisor or back-up supervisor by the Board? Yes No

If not approved, what is the status of your approval? Please explain, including name and address of intended supervising physician:

If approved, give name and address of supervising physician:

- b) Are you familiar with the Approved Formulary for the writing of prescriptions by persons licensed and approved to practice Midwifery? Yes No

- c) Do you perform or assist with deliveries in non-hospital settings? Yes No

- d) Do you practice at a site away from the direct supervision of your approved supervising Physician? If yes, please explain: Yes No

Nurse Anesthetist

- a) Please provide the name and address of your supervising physician(s).

- b) Do you administer anesthesia when an anesthesiologist is not physically present? If yes, please explain: Yes No

- c) Do you ever administer anesthesia under the supervision of a physician other than an anesthesiologist? Yes No
 If yes, please explain including name and address of supervising physician:

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 Back 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:			

