Medical Mutual℠
PROTECTING OUR PROFESSION

Notification to add Locum Tenens Physician or **Advanced Practice Provider**

This request is for a: ☐ Locum Tenens Physician ☐ Locum Tenens **Advanced Practice Provider**

Name of **Insured** Physician or **Advanced Practice Provider** for whom locum tenens will be working:

_____ Policy Number _____

Name of Locum Tenens Physician or **Advanced Practice Provider**:

_____

Medical License Number: _____ State: _____

Board Certified: ☐ Yes ☐ No
If yes: Name of Certifying Board: _____

Dates Locum Tenens worked in practice: _____
This notification must be received within 30 days of above dates in order for coverage to be effective.

Note:

- A physician can only substitute for another physician and an **Advanced Practice Provider** for another **Advanced Practice Provider**.

Please have the Physician or **Advanced Practice Provider** for whom this locum tenens substituted read and sign below:

Authorization by Substituted **Insured** Physician or **Advanced Practice Provider**

I hereby acknowledge and authorize the Company to add the above named locum tenens to my coverage for the dates noted above. I understand that I have no Medical Professional Liability coverage for any **Professional Services** I might render or fail to render on these dates, and that the named locum tenens will share in my Limits of Liability during such substitution. I further acknowledge that I am responsible for ensuring that the above named physician or **Advanced Practice Provider** is, to the best of my knowledge, competent, is in compliance with the applicable state licensing board and that he/she possesses qualifications similar to my own.

_____ _____
Signature of **Insured** Physician or **Advanced Practice Provider** Date

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