

MEDICAL TRAINING AND PRACTICE HISTORY

11. Medical Specialty: _____ Percent of Practice: _____

Medical Sub Specialty: _____ Percent of Practice: _____

Hospital/ College	City & State	Completed?	Year
Medical School: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Internship: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Residency: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Additional Residency: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Fellowship: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

13. Are you a U.S. citizen? Yes No If NO, please provide a copy of documents confirming your status.

14. Are you a Foreign Medical School Graduate? Yes No Date of ECFMG certification: _____

15. Are you currently Board Certified? Yes No Name of Board: _____

16. Date you began practicing _____ Within the last five (5) years have your practice characteristics, procedures performed, or business association(s) changed? Yes No If YES, please describe on additional sheet.

17. List all primary office locations where you have practiced in the last ten (10) years? (Use separate sheet if more space needed)

Street Address & City	County	State	Dates From / To

18. Please list all hospitals where you have staff privileges. (If no such privileges, attach protocol for patient hospital admission).

Hospital	City/ State	County	% of Practice

19. List states where you practice: Medical License Number(s): DEA License Number(s): % of practice in each state:
Please also indicate all states where you have been previously licensed:

20. Please indicate the number of CME hours you have obtained in the past two years: _____

II. OFFICE STAFF

21. Do you employ, contract with or supervise any physician(s) or surgeons(s)? Yes No IF YES, advise of number and attach current certificate(s) of insurance.

22. Do you employ, contract with or supervise any non-physician health care extenders? Yes No If YES, enter details below:

Number	Number	Others (Please Describe)	Number
Nurse Practitioner _____	Laboratory Technician _____	_____	_____
Physician Assistant _____	CRNA _____	_____	_____
Radiology Technician _____		_____	_____
Surgeon Assistant _____	Midwife _____	_____	_____
Pharmacist _____	Nurses _____	_____	_____

III. PRACTICE INFORMATION

23. Average Number of patients seen each week: _____ Weekly practice hours: _____ Percentage Locum Tenens work: _____ %

24. Please list any medical association membership(s): _____

25. Do you own, operate, administer, maintain a relationship with, or supervise any overnight bed and board facility, urgent care facility, commercial laboratory, urgent care center, surgi-center, abortion clinic, walk-in clinic, or birthing center? Yes No If YES, please describe on separate sheet.

26. Do you perform abortions? Yes No If YES, indicate number each month: _____ Type: Elective Therapeutic
Where performed? (Check all that apply) Office Hospital Other (Explain on separate sheet)
Maximum Gestation Age? _____

27. Does your practice include the following (Check all that apply)?

<input type="checkbox"/> No Surgery No surgery, with the exception of incision of sebaceous boils and cysts. Incision and removal of foreign body from superficial or subcutaneous tissue. Localized treatment of second and third degree burns and umbilical and urethral catheterization.
<input type="checkbox"/> Minor Surgery Applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following techniques or procedures: colonoscopy, endoscopic retrograde cholangiopancreatography (ERCP). pneumatic or mechanical esophageal dilation (not with bougie or olive). No general anesthesia.
<input type="checkbox"/> Major Surgery Involves operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or the length of circumstances of an operation. It also includes removal of tumors (except skin tumors), reduction of open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery, tonsillectomies, adenoidectomies, cesarean sections and any other operation using general anesthesia.
<input type="checkbox"/> Obstetrics If checked, please indicate annual: Number of vaginal deliveries: _____ Number of cesarean sections: _____ Number of VBAC: _____ Number of Home or Non-Hospital Deliveries: _____ (Please describe on separate sheet)
<input type="checkbox"/> Elective Plastic Surgery Please describe procedures and annual number performed on separate sheet

28. Do YOU perform any of the following procedures?

Acupuncture? <input type="checkbox"/> Yes <input type="checkbox"/> No	Laparoscopies? <input type="checkbox"/> Yes <input type="checkbox"/> No
Amniocentesis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Laser Treatments Via Endoscope? <input type="checkbox"/> Yes <input type="checkbox"/> No
Amputations? <input type="checkbox"/> Yes <input type="checkbox"/> No	Low Forceps Deliveries? <input type="checkbox"/> Yes <input type="checkbox"/> No
Angiography? <input type="checkbox"/> Yes <input type="checkbox"/> No	Malignant Lesion Surgical Procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No
Arteriography? <input type="checkbox"/> Yes <input type="checkbox"/> No	Mastoidectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Assisting in surgery on other than your own patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	Middle or Inner Ear Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
Assisting in surgery on your own patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	Mid-Forceps Delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No
Bariatric Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	MOHS Micrographic Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
Blepharoplasty? <input type="checkbox"/> Yes <input type="checkbox"/> No	Myleography? <input type="checkbox"/> Yes <input type="checkbox"/> No
Breast Augmentation or Reduction <input type="checkbox"/> Yes <input type="checkbox"/> No	Needle Biopsies? <input type="checkbox"/> Yes <input type="checkbox"/> No
Breech Deliveries? <input type="checkbox"/> Yes <input type="checkbox"/> No	Neurological Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
Catherizations? (Right Heart) <input type="checkbox"/> Yes <input type="checkbox"/> No	Norplant Insertion? <input type="checkbox"/> Yes <input type="checkbox"/> No
Cervical Biopsy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Obesity/Weight Control Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
Cervical Caутery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Office Gynecology? <input type="checkbox"/> Yes <input type="checkbox"/> No
Chelation Therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No Office	Oophorectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Peels? <input type="checkbox"/> Yes <input type="checkbox"/> No	Open Reduction Fractures? (Plating and Pinning) <input type="checkbox"/> Yes <input type="checkbox"/> No
Cleft Lip Palate Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ophthalmologic Surgery? (Laser or other) <input type="checkbox"/> Yes <input type="checkbox"/> No
Clinical Trials? <input type="checkbox"/> Yes <input type="checkbox"/> No	Organ Transplants? <input type="checkbox"/> Yes <input type="checkbox"/> No
Closed Reduction of Fractures? <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic Surgery? (Including Spinal Surgery) <input type="checkbox"/> Yes <input type="checkbox"/> No
Collagen Lip Injection? <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthopedic Surgery? (No Spinal Surgery) <input type="checkbox"/> Yes <input type="checkbox"/> No
Colonoscopy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Otoplasty? <input type="checkbox"/> Yes <input type="checkbox"/> No
Complex Flaps and Grafts <input type="checkbox"/> Yes <input type="checkbox"/> No	Pedicle Screw Insertion? <input type="checkbox"/> Yes <input type="checkbox"/> No
Conization of Cervix? <input type="checkbox"/> Yes <input type="checkbox"/> No	Penile Augmentation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Cosmetic Plastic Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Penile Implants? <input type="checkbox"/> Yes <input type="checkbox"/> No
Culdocentesis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pericardiocentesis? <input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnostic Radiology? <input type="checkbox"/> Yes <input type="checkbox"/> No	Permanent Eyeliner Procedures <input type="checkbox"/> Yes <input type="checkbox"/> No
Dilation and Curettage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnancy Care into Second Trimester? <input type="checkbox"/> Yes <input type="checkbox"/> No Endoscopic
Electroshock Therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Retrograde/Cholanagiopancreatography? <input type="checkbox"/> Yes <input type="checkbox"/> No
Endometrial Biopsy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pregnancy Care into Third Trimester <input type="checkbox"/> Yes <input type="checkbox"/> No
Episiotomy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Prostatectomy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Experimental Procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Therapy? (Radium Implants) <input type="checkbox"/> Yes <input type="checkbox"/> No
Gastric Bubble Procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No	Reconstructive Plastic Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hair Transplant Procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No	Scalp Reduction Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
High Risk Pregnancies <input type="checkbox"/> Yes <input type="checkbox"/> No	Sex Change Operations? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hyperbaric Chamber Treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sterilization Procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hypnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Suction Lipectomy Procedures? <input type="checkbox"/> Yes <input type="checkbox"/> No
Interphalangeal Joint Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Thrombectomy of Arteries and Veins? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hysterectomies <input type="checkbox"/> Yes <input type="checkbox"/> No	Toxemia Management? <input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Replacement Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Vascular Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney, Ureter and Bladder Surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	

29. Have your hospital privileges ever been suspended, restricted, denied, placed in probationary status, or revoked Yes No
IF YES, please describe on separate sheet.
30. Has your board certification or membership in any medical society/association ever been refused, suspended, revoked or voluntarily surrendered? Yes No IF YES please describe on separate sheet.
31. Are you now, or have you ever been involved in any Professional Liability claim or suit? Yes No IF YES a **Claim Information Supplement** form must be completed for each claim.
32. Are you aware of any circumstances that might lead to a claim or suit? Yes No IF YES, complete a **Claim Information Supplement** for each circumstance. Has this information been reported to a current or prior insurance carrier? Yes No
33. Has your Professional Liability insurance ever been refused, canceled or non-renewed? Yes No
IF YES, please explain on a separate sheet. (Response not required in the State of Missouri)
34. Has your medical license(s) or narcotics license(s) ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? Yes No IF YES, please explain on a separate sheet.
35. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or a mental or chronic physical illness? Yes No IF YES, please complete supplemental application.
36. Have you ever been charged with, or convicted of a crime other than minor traffic violations? Yes No IF YES, please explain on a separate sheet.
37. Have any fee or professional relations complaints been registered against you with your medical association(s), hospital(s) or a state licensing authority? Yes No IF YES, please explain on a separate sheet.
38. Has your board certification or membership in any medical society/association ever been refused, suspended, revoked or voluntarily surrendered? Yes No IF YES, please explain on a separate sheet.
39. Do you own or operate a Laboratory? Yes No IF YES:
(a) Does the laboratory provide services solely for your patients? Yes No
(b) If not limited to your patients, please explain on separate sheet.
40. Are you now or have you ever performed experimental or investigational procedures or prescribed or dispensed experimental drugs? Yes No IF YES, please explain on a separate sheet.
41. Do you now or have you treated prisoners in a state, federal or any correctional institution? Yes No
42. Do you practice as a company doctor (excluding treatment of workers comp patients)? Yes No IF YES, what products are manufactured by the company? _____
Do you review or establish plant / employer safety standards? Yes No
Do you provide medical treatment to company employees? Yes No
Company name: _____ Location: _____
43. Does your practice include weight reduction/control by other than diet and exercise? Yes No IF YES, please complete the information below or attach separate sheet if needed:
a. What percentage of patients are treated exclusively for weight control? ___ %
b. List injections used for weight control: _____
c. If you prescribe or dispense drugs for weight control, please list drugs and describe protocols: _____
d. Describe any other weight control procedures, including surgery, that you provide to your patients:
44. Do you authorize any collection agency, at its own discretion, to file a claim or suit? Yes No
45. Do you work in an Emergency Room for other than maintaining hospital privileges? Yes No
Please indicate the average number of hours you work in the Emergency Room each month: _____

46. Are you a sports team physician or health care provider? Yes No

IF YES, check all that apply: High School College Professional Other: _____

Name and location of team(s)? _____

47. Are you now, or have you ever been a proprietor, partner, officer, director, administrator, executive officer, or medical director, or are you under contract to provide professional services, at any Nursing Home or similar facility? Yes No

IF YES, describe percentage of your practice and name(s) of nursing home facilities:

48. Are you now, or have you ever been a proprietor, partner, officer, director, administrator, executive officer, or medical director of a hospital or hospital department; sanitarium; ambulatory care clinic with bed and board facilities; health maintenance organization; preferred provider organization; or any other business enterprise? Yes No

IF YES, please identify, provide address, and explain details on a separate sheet.

49. Do you serve in a "Gatekeeper" capacity (that is, the authorizing and/or rejecting of requests for hospitalization or specialized treatment(s), and/or determining the length of hospitalization or specialized treatments for or on behalf of any organization(s) for an HMO, PPO or similar Managed Care Organization)? Yes No

IF YES, please advise the percentage of your practice devoted to Gatekeeper activity: _____ %

50. Do you engage in telemedicine activity? IF YES, please describe on separate sheet. Yes No

51. Do you prescribe drugs or provide diagnosis via the internet? Yes No IF YES, please describe on separate sheet.

52. Do you endorse any products or participate in any activity which offers professional advice to the public, (e.g. newspaper columns, broadcasts, etc.)? Yes No IF YES, please describe on separate sheet.

IV. ANESTHESIA / OFFICE SURGERY

53. Do you perform or assist in any surgical procedure in your office or other non-hospital setting, during which anesthesia is administered by means other than a topical basis? Yes No IF YES, please complete the questions below:

a. Description and annual number of procedures: _____

b. Annual number of procedures with: General Anesthesia: _____ Spinal or Caudal Anesthesia: _____ Other: _____

c. Anesthesia administered by _____

d. Distance to nearest hospital: _____

e. Description of life saving equipment/supplies: _____

V. COVERAGE INFORMATION

54. Please list your previous professional liability insurance carrier(s) for the last five years and supply information requested below:

Insurance Company	Policy Limits	Coverage Dates	Type of Policy	Premium
		From:	<input type="checkbox"/> Occurrence	
		To:	<input type="checkbox"/> Claims Made	
		From:	<input type="checkbox"/> Occurrence	
		To:	<input type="checkbox"/> Claims Made	
		From:	<input type="checkbox"/> Occurrence	
		To:	<input type="checkbox"/> Claims Made	
		From:	<input type="checkbox"/> Occurrence	
		To:	<input type="checkbox"/> Claims Made	

55. Have you ever practiced without professional liability insurance? Yes No IF YES, specify dates:

56. Effective Date Desired: MO/DD/YR_____/_____/____ Retroactive Date Desired: MO/DD/YR_____/_____/_____
Important: *Declarations Page of your current policy must be attached if a retroactive date is requested. THE COMPANY MAY NOT PROVIDE DESIRED DATES.*

57. **Policy Limits Desired:** \$100,000/\$300,000 \$200,000/\$600,000 \$250,000/\$750,000
 \$1,000,000/\$3,000,000 Other: _____

VI. ACKNOWLEDGEMENTS, AUTHORIZATION AND SIGNATURE

This applicant declares that the information contained in the application is true and that no material facts have been suppressed or misstated.

The applicant understands and acknowledges that the information contained in the application is deemed material and that any policy issued by the Company is done so in reliance upon the truth of the applicant's representations.

This applicant understands that incorrect information could void coverage.

The applicant requests that this application for insurance coverage be submitted for consideration to _____ Company. Accordingly, the applicant authorizes and directs any person or organization whatsoever to release and furnish to the Company all information requested which may relate to the applicant's insurability. The applicant also consents to the review by the Company of any incidents or occurrences likely to result in a malpractice allegation or claim. The applicant agrees to cooperate in the review of claims which apply to the coverage requested.

THE APPLICANT UNDERSTANDS THAT COMPLETION OF THIS APPLICATION NEITHER BINDS COVERAGE NOR GUARANTEES THAT A POLICY WILL BE ISSUED.

This application must be reviewed, signed and dated by a principal, partner or officer of the applicant firm. It is understood and agreed that this application does not bind the insurance company to sell nor the applicant to purchase the insurance.

The undersigned, being authorized by and acting on behalf of all prospective insureds, represents that to the best of his/her knowledge, and after specific inquiry of all such prospective insureds, the answers given with respect to the foregoing questions are true and agrees that this application, together with all attachments to this application and any other materials submitted to the Insurance Company (all of which attachments and materials shall be deemed attached to the policy as if physically attached thereto), shall be the basis of and a part of any policy that may be issued by the Insurance Company. In the event of a material change in the applicant's practice or information provided in this application prior to the effective date of coverage, the applicant agrees to notify the Insurance Company of such change, and the Insurance Company, at its option, may modify, or withdraw, the quotation.

The Statement captioned below is applicable in all states except those specified below:

Any person knowingly and with intent to defraud any insurance company or other person files an application for insurance of statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which is a crime, and is subject to criminal and civil penalties. Penalties may include imprisonment, fines, denial of insurance, and/or civil damages.

Notice to Arkansas and New Mexico Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance

company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement of award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Authorities.

Notice to District of Columbia Applicants: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Notice to Florida Applicants: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

Notice to Kentucky Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Notice to Louisiana Applicants: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Notice to Maine Applicants: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to New York Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Notice to Ohio Applicants: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Notice to Oklahoma Applicants: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony (365:15-1-10, 36 §3613.1).

Notice to Pennsylvania Applicants: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Notice to Tennessee and Virginia Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The applicant agrees that in the event of a covered claim(s), it will be defended by the Insurer's appointed attorneys and that the deductible shall apply to Damages and Defense Costs as those terms are defined in this policy, if issued. The applicant understands that if it elects to handle a claim(s) without prior notice to and prior approval of the Insurer, then no coverage for such a claim(s) shall be afforded under any policy issued by the Insurer.

The information specified in this application is subject to audit in accordance with the terms of the policy, if issued.

Please Print Name: _____ (Must be principal, partner or officer)

Signature: _____ Title: _____

Date: _____

AMERICAN INTERNATIONAL COMPANIES⁰

Name Of Insurance Company
To Which Application Is Made: _____
(herein called the Company)

**PHYSICIAN/SURGEON PROFESSIONAL LIABILITY INSURANCE
SUPPLEMENTAL CLAIM FORM**

Complete a SEPARATE Supplemental Claim Form for each actual or potential claim. Answer EACH question fully.

1. Applicant's Name: _____
2. Full Name of individual(s) or applicant involved in the claim: _____
3. Additional Defendants: _____
4. Full name of Claimant: _____
5. (a) Date of alleged error: _____ (b) Date claim was made: _____
6. To what insurance company did you report this claim? _____
7. Present status of claim (circle one) Open/Incident In suit Closed
8. If Closed:
 - a) Total damages paid and outstanding(including deductible): _____
 - b) Total defense costs paid: _____
 - c) Date closed: _____
9. If Open/Pending:
 - a) Claimant's settlement demand: \$ _____ c) Insurer's Reserve: \$ _____
 - b) Defendant's offer for settlement: \$ _____ d) Amount paid to date: \$ _____
10. Description of claim or incident. Please provide on a separate sheet. Do not instruct to refer to file, or contact Company representative. Information must be provided to allow an evaluation of the claim or incident.
 - a) What is claimant's basis for the allegation: _____

 - b) Description of case and events: _____

11. What steps have been taken to prevent a similar claim? _____

This document will be attached to the Application and become part of the applicant's Physician/Surgeon Professional Liability Insurance Policy.

Signature of Physician/Surgeon: _____

Title: _____