



AltaCover<sup>sm</sup>

# HEALTH CARE PROFESSIONAL LIABILITY INSURANCE APPLICATION PHYSICIANS AND SURGEONS

With your fully completed, signed and dated application, you **must** submit the following information:

1. Current insurance policy declarations page.
2. Written verification of the purchase of a reporting endorsement from your present carrier if your current coverage is claims-made.
3. Current business letterhead.
4. Copy of all licenses and board certifications.
5. Currently valued loss runs from all prior insurance companies.
6. Copy of curriculum vitae.
7. Articles of Incorporation, if applicable.

**NOTE: SUBMISSION OF A COMPLETED APPLICATION CONFERS NO OBLIGATION UPON THE COMPANY TO BIND COVERAGE.**

Healthcare Professional Services, Inc. □  
313 Swanson Drive\*Lawrenceville, GA 30043 □  
(800) 423-1520 / (888) 206-2024 fax

NOTE: If any space provided herein is insufficient for complete reply, please use Page 15, and/or a separate sheet, identifying by number the questions you answer.

**1. PERSONAL INFORMATION**

Full Name of Applicant: \_\_\_\_\_  MD  DO  \_\_\_\_\_  
FIRST MIDDLE LAST SUFFIX

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
MONTH DAY YEAR

Social Security Number: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Home Address: \_\_\_\_\_  
 \_\_\_\_\_  
CITY COUNTY STATE ZIP

**2. OFFICE INFORMATION**

Principal Office Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
CITY COUNTY STATE ZIP

Please check this box if your Principal Office Address is not actually located within the city limits of the city to which your mail is addressed. ....

Office Phone Number: ( ) \_\_\_\_\_ Office Fax Number: ( ) \_\_\_\_\_

Secondary Office Locations (if any): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
CITY STATE ZIP

Secondary Office Phone No.: ( ) \_\_\_\_\_ Secondary Office Fax No.: ( ) \_\_\_\_\_

Preferred Billing Address:  Principal Office  Secondary Office  Home

Preferred Contact Person: \_\_\_\_\_ at  Principal Office  Secondary Office

Percentage of practice at each of the above locations: \_\_\_\_\_ Principal Office \_\_\_\_\_ Secondary Office

E-mail Address(s): \_\_\_\_\_

**3. EDUCATIONAL INFORMATION**

MEDICAL SCHOOLS			
NAME OF MEDICAL SCHOOL(S) ATTENDED	LOCATION OF SCHOOL(S) ATTENDED	DEGREE	DATE GRADUATED

RESIDENCIES, FELLOWSHIPS, AND OTHER POST-GRADUATE TRAINING					
INSTITUTION	LOCATION	SPECIALTY OR DEPARTMENT	DATES (MONTH/YEAR)		COMPLETED? CIRCLE ONE
			START	END	
					YES NO*
					YES NO*
					YES NO*
					YES NO*

\* IF "NO" CIRCLED, EXPLAIN FULLY ON PAGE 15 OR A SEPARATE SHEET

**CATEGORY I CONTINUING MEDICAL EDUCATION COMPLETED IN PAST THREE YEARS**

COURSES COMPLETED	CREDITS RECEIVED	DATES ATTENDED
List all others on page 15		

**4. PRACTICE HISTORY**

**PLEASE LIST ALL LOCATIONS WHERE YOU HAVE PRACTICED SINCE RESIDENCY**

LOCATIONS	DATES ( MONTH/YEAR)*	
	START	END
*PROVIDE BRIEF DESCRIPTION OF EACH PRACTICE SITUATION, INCLUDING CLINICAL RESPONSIBILITIES, AND EXPLAIN ANY GAPS IN PRACTICE ON PAGE 15 OR A SEPARATE SHEET		

**5. LICENSING AND BOARD CERTIFICATIONS**

A. Licensing (List all states in which you are currently licensed.)

<u>STATE</u>	<u>LICENSE NUMBER</u>	<u>% OF PRACTICE</u>	<u>WHICH COUNTY?</u>	<u>MEMBER OF STATE MEDICAL ASSOCIATION?</u>
_____	_____	_____	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
_____	_____	_____	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>
_____	_____	_____	_____	YES <input type="checkbox"/> NO <input type="checkbox"/>

B. If you are a foreign graduate, are you certified by the Educational Commission for Foreign Medical Graduates?..... YES  NO

C. Are you American Board Certified? ..... YES  NO

- i. If "yes," list Specialty Board(s): \_\_\_\_\_ (Indicate allopathic or osteopathic)
- ii. If "yes," list date of initial Board Certification: \_\_\_\_\_
- iii. If applicable, list date of re-certification(s): \_\_\_\_\_
- iv. If "no," are you Board eligible?..... YES  NO
- v. If Board eligible, when do you plan to take your Boards? \_\_\_\_\_

**6. PRACTICE ORGANIZATION**

A. Please check all that apply and provide details. If vicarious liability coverage is desired, so indicate.

- Solo Entity: Name \_\_\_\_\_  
 Corp. Tax ID # \_\_\_\_\_ Date of Incorporation \_\_\_\_\_  Coverage Requested
- Member of a partnership or multi-shareholder corporation: \_\_\_\_\_  
 Partnership/Group Name \_\_\_\_\_  
 Corp. Tax ID # \_\_\_\_\_ Date of Incorporation \_\_\_\_\_  Coverage Requested

Other - please explain: \_\_\_\_\_

Entity Name \_\_\_\_\_

Corp. Tax ID # \_\_\_\_\_ Date of Incorporation \_\_\_\_\_  Coverage Requested

**Please include Articles of Incorporation and any amendments, a list of principals, and a copy of your business letterhead.**

B. Give the full names of all other physicians affiliated with any organization(s) named in Question 6A, above. Use Page 15, if necessary.

NAME	CURRENT PROFESSIONAL LIABILITY INSURANCE CO.

**7. HOSPITAL AFFILIATIONS AND PRIVILEGES**

HOSPITALS WHERE YOU HAVE, OR HAD, ACTIVE PRIVILEGES OR WHERE YOU HAVE APPLIED						
HOSPITAL DATA		DATES (MONTH/YEAR)		% OF YOUR PATIENTS ADMITTED TO THIS FACILITY	ISSUE CERTIFICATE OF INSURANCE? (CIRCLE ONE)	
NAME	MAILING ADDRESS	START	END		YES	NO

**8. INFORMATION ON ALLIED HEALTH CARE PROFESSIONALS**

A. List below any of the following professionals associated with your practice:

**Anesthesia Assistants, Certified Registered Nurse Anesthetists, Cytotechnologists, Emergency Medical Technicians, Nurse Practitioners, Nurse Midwives, Optometrists, Perfusionists, Physician Assistants, Psychologists, Surgeon’s Assistants.**

Please indicate if coverage is desired for these individuals. A separate application will be required for each individual for whom coverage is requested.

NAME	SPECIALTY	EMPLOYMENT STATUS	TO BE CONSIDERED FOR SHARED LIMITS COVERAGE?
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> Yes <input type="checkbox"/> No

B. If you employ a Nurse Midwife, how many deliveries does that individual perform annually? If more than one midwife, respond for each separately. \_\_\_\_\_

\_\_\_\_\_

C. Indicate the number of the following types of employees who provide services in your office:

NUMBER	POSITION	NUMBER	POSITION
	Medical Assistant		Nurse (Registered or Licensed Vocational)
	Psychotherapist		Technician (Lab, Pathology, Dialysis, etc.)
	X-Ray Technician		Other:

D. Do any of your employees practice at a location geographically separate from yours? ..... YES  NO

If "yes," please explain. \_\_\_\_\_  
 \_\_\_\_\_

**9. PROFESSIONAL LIABILITY INSURANCE HISTORY**

NAME OF COMPANY (CURRENT)	POLICY LIMITS	PERIOD OF COVERAGE:  RETROACTIVE DATE:	<input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCURRENCE
NAME OF COMPANY	POLICY LIMITS	PERIOD OF COVERAGE:  RETROACTIVE DATE:	<input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCURRENCE
NAME OF COMPANY	POLICY LIMITS	PERIOD OF COVERAGE:  RETROACTIVE DATE:	<input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCURRENCE

- A. Have you ever applied to Mutual Assurance, Medical Assurance, ProNational Insurance Company, Red Mountain Casualty or ProAssurance for insurance before? ..... YES  NO
- B. If you have been insured under a Claims-Made policy, are you requesting that the Company provide prior acts coverage? ..... YES  NO
- C. If the Company does not offer you prior acts coverage, will you purchase "tail" coverage from your current carrier? If not, please explain on page 15. .... YES  NO
- D. Has any insurance company (including Lloyds of London) ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? If "yes," please provide complete explanation on page 15 ..... YES  NO

**Important information regarding questions 9E and 9F (including sub-questions)**

1. The word "claim" as used in questions 9E and 9F following refers to:
  - a. Any demand for damages, resolved or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate, employee or professional corporation or partnership; or
  - b. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you or any partner, associate, employee or professional corporation or partnership.
2. If you answer "yes" to any parts of questions 9E or 9F, please complete the attached Supplementary Claims Information Form on page 16 for all such claims.

E. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? .... YES  NO   
 If "yes," how many? \_\_\_\_\_ Please provide details for each on page 16.

- F. Other than the claims/suits indicated in 9E, are you aware of any of the following circumstances that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit?
- i. A request for records from a patient and/or attorney related to an adverse outcome?... YES  NO
  - ii. A letter from an attorney regarding your medical treatment of a patient? ..... YES  NO
  - iii. Intra-operative or post-operative complications or other complications resulting in death, paralysis, other significant disability or the need for follow-up surgery? ..... YES  NO
  - iv. Patient or family member dissatisfaction with the outcome of a procedure, treatment or diagnosis? ..... YES  NO
  - v. Any other circumstances that might reasonably lead to a claim or suit? ..... YES  NO
  - vi. Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier? ..... YES  NO 
    - a. If "Yes", how many? \_\_\_\_\_ Please attach documentation of all such reports.
    - b. If "No", please explain on page 15.

For purposes of this question, check the following box if you are aware of no circumstances that might reasonably lead to a claim or suit. .... Not Applicable

**If you answer "yes" to questions 9G through 9P, please provide details on page 15.**

- G. Has your license to practice or your permit to prescribe drugs ever been denied, revoked, suspended, voluntarily surrendered, or otherwise investigated or limited in any way? ..... YES  NO
- H. Have your hospital staff privileges ever been suspended, revoked, voluntarily surrendered, or in any way restricted? ..... YES  NO
- I. Have you ever failed any licensing or Board Certification examinations? ..... YES  NO   
If yes, how many times? .....
- J. Have you ever been refused hospital privileges? ..... YES  NO
- K. Have you ever appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical or Dental Examiners, or other medical or dental review committee? ..... YES  NO
- L. Have you ever had a patient or a patient representative complain to or file a grievance of any type with a hospital committee, state licensing Board, Board of Medical or Dental Examiners, or other medical or dental review committee? ..... YES  NO
- M. Have you ever been convicted of, pled guilty to or entered into a plea agreement for a violation of any law or ordinance other than traffic offenses, but including driving while under the influence of alcohol or any other substance? ..... YES  NO
- N. Have you ever been evaluated for, recommended for treatment of, diagnosed with or treated for alcohol, narcotics or any other substance abuse, sexual addiction, anger management or any other mental illness, including but not limited to depression and/or chronic fatigue? ..... YES  NO
- O. Have you ever been accused of sexual misconduct of any kind? ..... YES  NO
- P. Do you have any physical handicap or any chronic illness? ..... YES  NO
- Q. Have you or your practice been the subject of any billing or reimbursement inquiry or investigation by any governmental agency, private health insurance payors or public health insurance payors, including, but not limited to, Medicare or Medicaid? ..... YES  NO

If "yes," explain in detail on page 15 including the date(s) and resolution, if any. \_\_\_\_\_

**10. COVERAGE REQUEST**

Requested Effective Date: \_\_\_\_\_  
MONTH DAY YEAR

A. Please indicate your desired level of coverage by placing an "X" in the appropriate box.

- \$100,000 / \$300,00       \$200,000 / \$600,00       \$250,000 / \$750,000
  - \$500,000 / \$1,500,000       \$1,000,000 / \$3,000,000       \$2,000,000 / \$6,000,000
- (Available only in the state of Virginia)

B. A deductible of at least \$5,000 is required. Please select any optional deductible that you desire. No aggregate limitation will apply to the deductible.

- \$10,000     \$25,000     \$50,000

**11. RATING AND CLASSIFICATION INFORMATION**

A. What is your present specialty? \_\_\_\_\_

B. What is your present sub-specialty? \_\_\_\_\_

C. What percentage of your practice is devoted to your specialty? \_\_\_\_\_ % Sub-specialty \_\_\_\_\_ %

D. Have there been any changes in your specialty or practice activities (including the addition of new procedures) within the past ten years?..... YES  NO

If "yes," describe the nature of changes in specialty or practice activities \_\_\_\_\_

E. Do you anticipate any changes in your specialty or practice activities (including the addition of new procedures) in the next year? ..... YES  NO

If "yes," describe the anticipated changes in specialty or practice activities \_\_\_\_\_

F. Do you perform any procedures not routinely performed by other persons practicing your specialty or subspecialty? ..... YES  NO

If "yes," please give complete details \_\_\_\_\_

G. Indicate the average number of: Patients seen per week: \_\_\_\_\_ Hours practiced per week: \_\_\_\_\_

H. How many hours per week are you on call? \_\_\_\_\_

I. If applying for obstetrical coverage, indicate  
i. Average number of deliveries per year \_\_\_\_\_

ii. Percentage of high-risk deliveries \_\_\_\_\_

iii. Average number of VBAC deliveries \_\_\_\_\_

iv. What induction agents do you use on VBAC patients? \_\_\_\_\_

v. Do you have privileges to perform C-sections at each hospital you staff? ..... YES  NO

J. Do you practice Bariatric medicine? ..... YES  NO

i. If "yes," what drugs do you utilize for weight loss? \_\_\_\_\_

ii. Do you perform Bariatric surgery? ..... YES  NO

iii. If "yes," what percentage of your practice does such surgery constitute? \_\_\_\_\_

K. Do you now or have you ever provided services to any state, local or federal correctional facility, jail or prison?..... YES  NO

If "yes," please explain: \_\_\_\_\_

L. Do you treat patients in a nursing home or similar facility?..... YES  NO

If "yes," how many patients do you treat there per month, on average? \_\_\_\_\_

M. Do you serve as a medical director of a hospital, nursing home, or other facility? ..... YES  NO

If "yes," please provide details: \_\_\_\_\_

- N. Do you or will you staff an emergency room?..... YES  NO
- i. If "yes," how many hours per week? \_\_\_\_\_
- ii. If "yes," in what facilities or for what staffing company? \_\_\_\_\_
- iii. Is this emergency room practice required for staff privileges?..... YES  NO
- O. Do you render care or perform consultations outside the state of your primary office location, including but not limited to the use of telecommunication technology as a medium for rendering medical services (telemedicine or internet medicine)? ..... YES  NO
- i. If "yes," indicate all states where you see patients or where the patients being treated reside: \_\_\_\_\_
- ii. What percentage of your total practice does this extra-state activity constitute? \_\_\_\_\_
- P. Do you read or interpret films, slides or specimens of patients who reside in states other than your indicated state of practice? ..... YES  NO
- If "yes," please explain and indicate all states in which the patients reside. Indicate the percentage of your practice corresponding to each such state: \_\_\_\_\_
- \_\_\_\_\_
- Q. Will you read your own x-rays?..... YES  NO
- i. If "yes," will they subsequently be read by a radiologist?..... YES  NO
- ii. If "yes," within how many hours? \_\_\_\_\_
- R. Do you perform hospital surgical procedures using nurse anesthetists to administer anesthesia who are not directed by or responsible to an anesthesiologist? ..... YES  NO
- If "yes," explain the type and volume of such surgeries and the average number of cases per month. \_\_\_\_\_
- S. Do you perform surgical procedures at a same day surgery center other than your office? YES  NO
- i. If "yes," what facility? \_\_\_\_\_
- ii. How many procedures do you perform there annually? \_\_\_\_\_
- T. Do you perform surgery in your office or private suite using anesthesia other than local?... YES  NO
- If "yes," you must complete the **Office Anesthesia Questionnaire in Section 12**.
- U. Are you a sports team physician for any college, university, semi-professional or professional team? ..... YES  NO
- If "yes," please explain. \_\_\_\_\_
- V. Do you practice any of the following forms of "Alternative Medicine"?
- |                      |  |                       |  |
|----------------------|--|-----------------------|--|
| Ayurvedic Medicine   | YES <input type="checkbox"/> NO <input type="checkbox"/> | Chiropractic Medicine | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Chinese Medicine     | YES <input type="checkbox"/> NO <input type="checkbox"/> | Holistic Medicine     | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| Homeopathic Medicine | YES <input type="checkbox"/> NO <input type="checkbox"/> | Naturopathic Medicine | YES <input type="checkbox"/> NO <input type="checkbox"/> |
- If you answered "yes" to any of the above, please describe your practice. \_\_\_\_\_
- \_\_\_\_\_
- W. Are you employed full time or part time by the federal, state or local government or are you on active military duty? ..... YES  NO
- If "yes," please explain the nature of your employment and why you desire coverage. \_\_\_\_\_
- \_\_\_\_\_

- X. Do you or does any partnership or corporation of which you are a member or shareholder own or operate a surgery center, medical laboratory, urgent care facility or other medical enterprise other than a physician office practice?..... YES  NO
- If "yes," please provide complete details on page 15. \_\_\_\_\_
- If "yes," is access limited to members of your practice? ..... YES  NO
- Y. Have you entered into any contracts with managed care organizations providing for capitated payments to you for patient care? ..... YES  NO
- If "yes," what percentage of your patients falls under such agreements? \_\_\_\_\_
- Z. Are you ACLS or ATLS certified? ..... YES  NO

**Please check any of the following that apply to your practice. If none apply, so indicate.**

<input type="checkbox"/> Abortion, elective <input type="checkbox"/> Acupuncture <input type="checkbox"/> Anesthesia <input type="checkbox"/> Caudal <input type="checkbox"/> Local <input type="checkbox"/> Spinal <input type="checkbox"/> Other _____ <input type="checkbox"/> Angiography <input type="checkbox"/> Angioplasty <input type="checkbox"/> Appendectomy <input type="checkbox"/> Arteriography <input type="checkbox"/> Arthroscopy <input type="checkbox"/> Assist in Major Surgery <input type="checkbox"/> On own patients <input type="checkbox"/> On patients of others <input type="checkbox"/> Bariatric procedures <input type="checkbox"/> Gastric banding <input type="checkbox"/> Gastric bubble <input type="checkbox"/> Gastric bypass <input type="checkbox"/> Gastric stapling <input type="checkbox"/> Blepharoplasty <input type="checkbox"/> Cosmetic <input type="checkbox"/> Reconstructive <input type="checkbox"/> Breast Biopsy <input type="checkbox"/> Breast Implants <input type="checkbox"/> Breast Reduction <input type="checkbox"/> Cardiac surgery <input type="checkbox"/> Cataract surgery <input type="checkbox"/> Chelation therapy <input type="checkbox"/> Chemonucleolysis <input type="checkbox"/> Cholecystectomy <input type="checkbox"/> Circumcision <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Colposcopy <input type="checkbox"/> Cryosurgery, other than external lesions <input type="checkbox"/> Dermatological procedures <input type="checkbox"/> Botox injection <input type="checkbox"/> Chemical peels <input type="checkbox"/> Chemobrasion <input type="checkbox"/> Collagen injection <input type="checkbox"/> Dermabrasion <input type="checkbox"/> Fat transfer <input type="checkbox"/> Hair transplant <input type="checkbox"/> Laser hair removal <input type="checkbox"/> Laser skin resurfacing <input type="checkbox"/> Microdermabrasion <input type="checkbox"/> Silicone injection <input type="checkbox"/> Other _____	<input type="checkbox"/> D & C <input type="checkbox"/> Dermatopathology <input type="checkbox"/> Echocardiography <input type="checkbox"/> Endoscopic laser therapy <input type="checkbox"/> Endoscopy <input type="checkbox"/> Cystoscopy <input type="checkbox"/> Bronchoscopy <input type="checkbox"/> EGD <input type="checkbox"/> Gastrosocopy <input type="checkbox"/> Hysteroscopy <input type="checkbox"/> Proctoscopy <input type="checkbox"/> Sigmoidoscopy <input type="checkbox"/> Other _____ <input type="checkbox"/> ERCP/ERC <input type="checkbox"/> Exchange transfusion <input type="checkbox"/> Facial plastic surgery <input type="checkbox"/> Elective cosmetic <input type="checkbox"/> Reconstructive <input type="checkbox"/> Fluoroscopy <input type="checkbox"/> Fracture Reduction <input type="checkbox"/> Closed <input type="checkbox"/> Open <input type="checkbox"/> Hand surgery <input type="checkbox"/> Hemorrhoidectomy <input type="checkbox"/> Hernia repair <input type="checkbox"/> Hip nailing <input type="checkbox"/> Hyperbaric medicine <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Intensive care for newborns <input type="checkbox"/> Intensive care medicine for adults <input type="checkbox"/> Infertility treatment <input type="checkbox"/> Medical <input type="checkbox"/> In vitro fertilization <input type="checkbox"/> Other surgical <input type="checkbox"/> Laminectomy <input type="checkbox"/> Laparoscopy <input type="checkbox"/> LASIK <input type="checkbox"/> Left heart catheterization <input type="checkbox"/> Liposuction <input type="checkbox"/> Tumescent <input type="checkbox"/> Other _____ <input type="checkbox"/> Lithotripsy <input type="checkbox"/> Mammography <input type="checkbox"/> Myelography <input type="checkbox"/> Myomectomy <input type="checkbox"/> Neonatology	<input type="checkbox"/> Organ transplantation <input type="checkbox"/> Orthopedic surgery <input type="checkbox"/> Including spinal surgery <input type="checkbox"/> Without spinal surgery <input type="checkbox"/> Osteopathic manipulative medicine <input type="checkbox"/> Pain management <input type="checkbox"/> Cordotomy <input type="checkbox"/> Dorsal root gangliotomy <input type="checkbox"/> Facet blocks <input type="checkbox"/> Medication only <input type="checkbox"/> Nerve root blocks <input type="checkbox"/> Pump implantation and removal <input type="checkbox"/> Rhizotomy <input type="checkbox"/> Sphenopalatine lesioning <input type="checkbox"/> Spinal injections <input type="checkbox"/> Thoracic sympathectomy <input type="checkbox"/> Trigeminal lesioning <input type="checkbox"/> Other _____ <input type="checkbox"/> Percutaneous vertebroplasty <input type="checkbox"/> Pacemaker placement <input type="checkbox"/> Polypectomy <input type="checkbox"/> Prenatal care <input type="checkbox"/> Prolotherapy <input type="checkbox"/> Provertin retinal therapy <input type="checkbox"/> Radiation therapy <input type="checkbox"/> Radiopaque dye injection <input type="checkbox"/> Roux-en-Y <input type="checkbox"/> Sclerotherapy <input type="checkbox"/> Spinal fusion <input type="checkbox"/> Spinal surgery, other _____% <input type="checkbox"/> Thoracic surgery _____% <input type="checkbox"/> Thyroidectomy <input type="checkbox"/> Tonsillectomy/adenoidectomy <input type="checkbox"/> Transgender surgery/hormonal gender conversion <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Vascular surgery _____% <input type="checkbox"/> Vasectomy  <input type="checkbox"/> <b>None of the above apply to my practice (Initial) _____</b>  <input type="checkbox"/> <b>Other procedures not listed above (Please list)</b> _____ _____ _____
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## 12. OFFICE ANESTHESIA QUESTIONNAIRE

**If you administer only local anesthesia in your office, you may skip this section and go to page 13. If you administer any anesthesia other than local in your office or private suite, you must complete this section.**

### A. Anesthesia Training/Education

- i. Describe your anesthesia training. \_\_\_\_\_  
\_\_\_\_\_
- ii. List Continuing Education courses you have taken in the last 5 years that are related to the use of anesthesia in an office setting.  
\_\_\_\_\_  
\_\_\_\_\_
- iii. During the last 5 years, have you participated in an office evaluation program performed by your peers or a risk management organization? ..... YES  NO

### B. Methods Utilized

Indicate the types of anesthesia you administer. Also, indicate the number of procedures performed under each type of anesthesia annually as well as the five most commonly performed procedures.

TYPES OF ANESTHESIA		NUMBER OF PROCEDURES	FIVE MOST COMMON PROCEDURES
Minimal Sedation (Anxiolysis)	<input type="checkbox"/> Y <input type="checkbox"/> N		
Moderate Sedation/Analgesia (Conscious Sedation)	<input type="checkbox"/> Y <input type="checkbox"/> N		
Deep Sedation/Analgesia	<input type="checkbox"/> Y <input type="checkbox"/> N		
General Anesthesia	<input type="checkbox"/> Y <input type="checkbox"/> N		

**Minimal Sedation (Anxiolysis)** is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

**Moderate Sedation/Analgesia (Conscious Sedation)** is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

**Deep Sedation/Analgesia** is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

**General Anesthesia** is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

### C. Personnel

- i. Complete the following table concerning others in your office that are involved in patient care related to anesthesia.

NAME	TITLE/SPECIALTY	EMPLOYMENT STATUS	CERTIFICATION
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> ACLS <input type="checkbox"/> BCLS
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> ACLS <input type="checkbox"/> BCLS
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> ACLS <input type="checkbox"/> BCLS
		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor	<input type="checkbox"/> ACLS <input type="checkbox"/> BCLS

ii. If you use contractors, how do you verify insurance, credentials and competency of contracted staff?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**D. Equipment**

i. Indicate which types of equipment are available and properly maintained in your office.

ECG	<input type="checkbox"/> Y <input type="checkbox"/> N	Temperature monitor	<input type="checkbox"/> Y <input type="checkbox"/> N
Oxygen source	<input type="checkbox"/> Y <input type="checkbox"/> N	IV set-up	<input type="checkbox"/> Y <input type="checkbox"/> N
Defibrillator	<input type="checkbox"/> Y <input type="checkbox"/> N	Blood pressure monitor	<input type="checkbox"/> Y <input type="checkbox"/> N
AMBU bag	<input type="checkbox"/> Y <input type="checkbox"/> N	Resuscitative & emergency drugs (crash cart)	<input type="checkbox"/> Y <input type="checkbox"/> N
Suction apparatus	<input type="checkbox"/> Y <input type="checkbox"/> N	Pulse oximeter	<input type="checkbox"/> Y <input type="checkbox"/> N
Intubation equipment	<input type="checkbox"/> Y <input type="checkbox"/> N		

ii. Who is responsible for maintaining the equipment and drugs? \_\_\_\_\_

\_\_\_\_\_

iii. Do you have an emergency power supply? ..... YES  NO

iv. How many bottles of oxygen do you keep on the premises? \_\_\_\_\_

v. Do you have a scavenging system for anesthetic gases? ..... YES  NO

**E. Pre-anesthesia Procedures**

i. Who performs a history and physical examination on the patient prior to administration of anesthesia? \_\_\_\_\_

ii. Who documents this history and physical? \_\_\_\_\_

iii. Does the history and physical include information concerning previous experiences with anesthesia? ..... YES  NO

iv. Are written discharge instructions provided to the patient or a responsible adult prior to the procedure? ..... YES  NO

**F. Intra-anesthesia Procedures**

i. Who performs the administration of anesthesia in your office? \_\_\_\_\_  
What are the qualifications of this individual? \_\_\_\_\_

ii. Is there a second individual monitoring the patient during the administration of anesthesia? ..... YES  NO   
If "yes," what are this individual's qualifications? \_\_\_\_\_

iii. How frequently do you monitor heart rate, blood pressure and temperature during anesthesia administration? \_\_\_\_\_

iv. Who documents intra-anesthesia monitoring? \_\_\_\_\_

v. Do you use pulse oximetry for patients under any level of anesthesia? ..... YES  NO   
If "no," please explain. \_\_\_\_\_

\_\_\_\_\_

vi. Are you equipped and trained to use positive pressure endotracheal respiratory assistance? ..... YES  NO



**IMPORTANT – YOU MUST READ CAREFULLY**

**GENERAL FRAUD WARNING**

**Any person who knowingly includes any false or misleading information on an application for an insurance policy or files a claim containing a false or deceptive statement is guilty of insurance fraud and is subject to criminal and civil penalties.**

**Consent, Warranty, Representations and Acknowledgement of Understanding**

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application, regardless of whether or not I am granted insurance, and for the duration of the insurance that may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release from any and all liability, the Company, its directors, officers, agents, members, employees and other authorized representatives, for any acts pertaining to my application for insurance, including ultimate cancellations, rejection, or approval for insurance, and any communications, reports, records, statements, documents, disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I hereby declare and warrant that the foregoing statements and particulars are, to the best of my knowledge, complete and correct and that I have not deliberately suppressed or misstated any material facts. I understand that this is an application for insurance and is not evidence of coverage.

I acknowledge that acceptance into the Company's insurance program is not a right of every licensed applicant and that my application will be evaluated by authorized personnel. Submission of a payment or a deposit with this application and provisional receipt thereof by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an applicant is not accepted, any such payment will be returned to the applicant. I further acknowledge that incomplete or incorrect information could result in retroactive premium adjustment, denial of coverage or voidance of any policy issued in reliance on such information.

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**Applicant's Signature**

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**Date**

## AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by RED MOUNTAIN CASUALTY INSURANCE COMPANY OR PRONATIONAL INSURANCE COMPANY (the "Company") hereby authorizes his present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned also authorizes all professional associations and societies in which he is or has been a member, all hospitals in which he now holds or has held staff privileges, any Board of Professional Examiners or Licensure Commission for any state in which he has practiced or resided, and any and all physicians, dentists or any other third party having information regarding the undersigned, to release to the Company upon its request any information that any such person or entity may have which in the judgment of such person or entity or the Company may have a bearing upon his acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a copy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): \_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_



**SUPPLEMENTAL CLAIMS INFORMATION**

**If reporting more than one claim, please photocopy this form, and complete a separate form for each. Attach additional sheets if needed for adequate explanation. All questions must be answered or marked Not Applicable (N/A).**

- 1. Patient's name: \_\_\_\_\_
- 2. Date reported to insurance company: \_\_\_\_\_
- 3. Name of Insurance Company: \_\_\_\_\_
- 4. Date of incident and your treatment: \_\_\_\_\_
- 5. Allegations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. What is the present condition of the patient? \_\_\_\_\_  
\_\_\_\_\_

7. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ..... YES  NO

8. Status of claim (check applicable answer):

- Suit threatened, no action taken
- Suit filed but dropped by claimant
- Summary judgment in your favor

- Suit settled out of court
  - a. Date claim paid: \_\_\_\_\_
  - b. Amount paid: \$ \_\_\_\_\_
  - c. Did you want to settle this claim?  YES  NO

- Court outcome in your favor:
- Jury verdict
  - Directed verdict

- Court outcome in favor of plaintiff:
- Jury verdict
  - Directed verdict
- Amt. of loss payment:  
\$ \_\_\_\_\_

- Unresolved/Open Claim:
- Awaiting mediation
  - Awaiting court action

Reserve Amount:  
\$ \_\_\_\_\_

9. Name and address of the attorney assigned to your case: \_\_\_\_\_  
\_\_\_\_\_

10. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)? ..... YES  NO

If "yes", amount was \$ \_\_\_\_\_

11. Explain, in detail, what action(s) you have taken to prevent recurrence of this type of claim: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (Printed): \_\_\_\_\_