

# Limited Professional Liability Insurance Application for Insured Paramedical Employees



ProAssurance Indemnity Company, Inc. • PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

Requested Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ License/NPI Number: \_\_\_\_\_

Name (Last, First, MI): \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: Male  Female

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Current Employer: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

1. Profession:
- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Physician Assistant     | <input type="checkbox"/> Perfusionist               | <input type="checkbox"/> Certified Nurse Practitioner           |
| <input type="checkbox"/> Surgical Assistant      | <input type="checkbox"/> Optometrist                | <input type="checkbox"/> Certified Registered Nurse Anesthetist |
| <input type="checkbox"/> Psychologist            | <input type="checkbox"/> Cytotechnologist           | <input type="checkbox"/> Emergency Medical Technician           |
| <input type="checkbox"/> Certified Nurse Midwife | <input type="checkbox"/> Anesthesiologist Assistant | OTHER: _____  |

2. Is your employer insured by a ProAssurance Company? Yes  No

3. Have you ever:
- A. Been convicted of a criminal offense? Yes  No
  - B. Been treated for (or recommended for treatment for) alcoholism, sexual, or drug addiction? Yes  No
  - C. Undergone psychiatric treatment? Yes  No
  - D. Had a complaint filed against you with any hospital or regulatory board? Yes  No
  - E. Had any professional license/permit or narcotics license investigated, suspended, revoked, restricted, or placed under probation? Yes  No

**If the answer to 3.A., 3.B., 3.C., 3.D., or 3.E. is yes, please provide complete details on a separate sheet of paper.**

4. Do you moonlight (work outside control of employer)? If yes, where? Yes  No

\_\_\_\_\_

\_\_\_\_\_

5. Do you hold the certification of licensure required in your state to practice your profession? Yes  No   
If yes, where did you receive your training?

\_\_\_\_\_

6. Are you a member of any professional organization? If yes, please give details. Yes  No

\_\_\_\_\_

7. Have any judgments ever been rendered against you or any out-of-court settlements in excess of \$500 been made on your behalf from an incident alleging professional errors or omissions? Yes  No   
If yes, please give details on a separate sheet. If available, please enclose copy of complaint.

8. Has any action been filed against you or have you been notified that any action, regardless of dollar amount, will be filed against you alleging professional errors or omissions? Yes  No   
If yes, please give details on a separate sheet. If available, please enclose copy of complaint.

9. Has an insurance company, including Lloyd's of London, ever canceled, declined to issue, refused to renew, surcharged your premium, or issued coverage with any restrictions or exclusions? *(This question not applicable in Missouri.)* Yes  No
10. Will you be scheduled to work at a separate location from your supervising physician?  
If yes, please give details on a separate sheet. Yes  No
11. Does your practice comply in every way with the rules and regulations as set forth by the agency in your state charged with licensing and monitoring individuals in your profession? Yes  No
12. Do you elicit, record, and evaluate a health, psychosocial, and developmental history of the patient? Yes  No
13. Do you order or perform diagnostic tests? Yes  No
14. Do you discriminate between normal and abnormal findings on the history, physical examination, diagnostic tests, initiate referrals and consultations when needed? Yes  No
15. Do you regulate or adjust medications and treatment as prescribed by or authorized by a licensed physician? Yes  No
16. Do you perform a physical examination?  
If yes, briefly describe techniques and instruments used: \_\_\_\_\_

17. Do you conduct informed consent discussions? Yes  No
18. Describe any other procedures, treatments, or duties you perform:  
\_\_\_\_\_  
\_\_\_\_\_

19. Describe your procedure for notifying your supervising physician of situations beyond the scope of your training or practice:  
\_\_\_\_\_  
\_\_\_\_\_

20. Please list all states in which you are licensed along with each license number and renewal date:

| State | License Number | Renewal Date |
|-------|----------------|--------------|
| _____ | _____          | _____        |
| _____ | _____          | _____        |
| _____ | _____          | _____        |
| _____ | _____          | _____        |
| _____ | _____          | _____        |

21. Please include copies of the following:
- A. Current Curriculum Vitae
  - B. Copy of your approved notification of supervision form
  - C. Copy of current professional liability insurance declarations page
  - D. Claims history
  - E. Copies of your practice protocols

**Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.**

**Consent to Conditions of Consideration of the Application for Insurance**

I understand that no coverage will be bound until after ProAssurance has reviewed my completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression by ProAssurance of intent to provide coverage. If ProAssurance declines to offer coverage, my advance payment will be promptly returned to me.

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 which may be issued to me.

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

I understand that should any incident, injury or death occur to any patient while under my care subsequent to my signing and dating this application, I must notify ProAssurance or its authorized agent or broker in writing of such event.

**Important:** Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event of a claim, could lead to a denial of liability. The following section is an Applicant’s Representation and Authorization from which requires your signature. Please read carefully.

**Applicant’s Representation and Authorization**

I, the undersigned, hereby authorize my present and prior professional liability carriers, any and all attorneys who have represented me in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding me, to release to ProAssurance, upon its request, any information which in the judgment of any such person noted above may have bearing upon my acceptability to ProAssurance and its subsidiaries or agents as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

I understand that third-party information, records or data regarding my practices, medical procedures and/or prescribing practices may be used for informational or underwriting purposes.

I hereby release and agree to hold harmless all persons or organizations, their agents, servants, and employees, ProAssurance, its directors, officers, employees and agents from any liability arising from releasing the above information, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

I further agree that ProAssurance and all persons and organizations described above may rely upon a photocopy of this Authorization, which shall be of equal validity with the signed original.

I hereby declare and represent that the foregoing statements and particulars are complete, to the best of my knowledge and recollection, and that I have not willfully concealed, omitted, or misrepresented any material fact or circumstance concerning this insurance or the subject thereof.

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

Applicant’s Signature: \_\_\_\_\_

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

Note: ProAssurance’s Privacy Policy can be found on ProAssurance.com.

**Insured Physician’s Authorization**

I hereby request the above applicant be added to my Policy as an Insured Paramedical Employee. I understand that such coverage is subject to underwriting approval.

Requested Effective Date: \_\_\_\_\_

Shared Limits Coverage

Separate Limits Coverage

Note: Separate Limits Coverage is not available for Cytotechnologists.

\_\_\_\_\_  
Signature of Insured Physician/Supervising Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please Print Name