Healthcare Facility Liability Application For Insured Paramedical Employees

ProAssurance. Treated Fairly

PO Box 590009 • Birmingham, AL 35259-0009 • 800.282.6242 • Fax 205.868.4040

Requested Effective Date: _____ /_____ /_____

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:

☐ Physician Assistant	☐ Perfusionist	☐ Certified Nurse Practitioner
☐ Surgical Assistant	☐ Optometrist	☐ Certified Registered Nurse Anesthetist
☐ Psychologist	☐ Cytotechnologist	☐ Emergency Medical Technician
☐ Certified Nurse Midwife	☐ Anesthesiologist Assistant	☐ Other, please specify: _____

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? Yes ☐ No ☐

10. Will you be scheduled to work at a separate location from your supervising physician? Yes ☐ No ☐
    If *yes*, please give details on a separate sheet.

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? Yes ☐ No ☐
    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 – 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

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

Consent to Conditions of Consideration of the 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 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.

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 Authorization to Release Information from which requires your signature. Please read carefully.

Name (Printed): _____

Applicant's Signature: _____

Title: _____ Date: _____

Agent Name: _____ License Number: _____