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

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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 – 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 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: _____

PROASSURANCE.
Treated Fairly

Important Notice About the Policy of Insurance for Which You Have Applied

This Document Affects Your Legal Rights

Read the Following Information Carefully

1. The policy for which you have applied includes a binding arbitration agreement.
2. The arbitration agreement requires that any disagreement related to this policy must be resolved by arbitration and not in a court of law.
3. The results of the arbitration are final and binding on you and the insurance company.
4. In an arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the positions of the parties.
5. When you accept this insurance policy you agree to resolve any disagreement related to the policy by binding arbitration instead of a trial in court including a trial by jury.
6. Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator cannot be reviewed in court by a judge and jury.

Acknowledgement of Arbitration Agreement

I have read this statement. I understand that I am voluntarily surrendering my right to have any disagreement between the insurance company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that upon receipt of the policy I should read the arbitration clause contained in the policy and that I have the right to reject this policy within three (3) days of the date of delivery if I do not want to accept the requirement for arbitration.

Applicant's Signature	Date	Time
Agent	Date	Time

Note: You will need to sign this notice to be considered for coverage.