# Medical Professional Liability Physician Renewal Application



# ProAssurance Indemnity Company, Inc. • PO Box 150 • Okemos, MI 48805-0150 • 800.282.6242 • Fax 205.414.2895

| Date:              | Policy #: | Expiration Date: |
|--------------------|-----------|------------------|
| Agent/Agency Name: |           | Phone:           |

Important: Please review, complete, and return this renewal application with a copy of your updated curriculum vitae and a copy of your current business letterhead. Please make any necessary changes to the pre-filled information below. Your prompt, accurate reply assists your policy's renewal. Thank you.

# 1. Personal Information

|    | Name: Degree:  |   |                    |  |
|----|----------------|---|--------------------|--|
|    | Em             | ail Address:  |                    |  |
|    | Hot            | ne Address:   |                    |  |
|    |                | : State: ZIP: Home Phone:   |                    |  |
|    |                | ctice Specialty:  |                    |  |
|    |                | dical License/NPI Number(s): State License/NPI Number Expiration Date   | % of Practice      |  |
| 2. |                | all State Medical Associations you currently belong to:   |                    |  |
| 2. |                | cipal Office Street Address:  |                    |  |
|    |                | : County: State: ZIP:   |                    |  |
|    |                | ice Phone: Office Fax: Website:   |                    |  |
|    |                |   |                    |  |
|    |                | ling Address:   |                    |  |
|    | Billi          | ng Address:   |                    |  |
|    | Cor            | tact Name: Title:   |                    |  |
|    | Cor            | ntact Email Address:  |                    |  |
| 3. | Pra            | ctice Information   |                    |  |
|    | А.<br>В.<br>С. | How many patients do you see on average per week?<br>How many hours do you practice per week?<br>(Practice hours include hospital rounds, charting, consultation with other physicians, patient visits/consultations, parame<br>and on-call hours involving patient contact—whether direct or by telephone.)<br>Please give us the name of any newly formed or dissolved solo or professional group practice entity<br>(e.g., P.A., P.C., L.L.C., L.L.P., Inc., etc.) or DBAs related to your practice: | dical supervision, |  |
|    |                | i. Do you desire coverage for this new entity?  | Yes 🗌 No 🗌         |  |
|    | D.             | Do you serve as a Medical Director?   | Yes 🗌 No 🗌         |  |
|    |                | If yes, please list the name of the facility(ies) and provide proof of coverage if insurance is provided by the facility for your duties as medical director:   |                    |  |
|    | E.             | Are you a professional sports team physician?   | Yes 🗌 No 🗌         |  |
|    |                | If yes, provide the name of the team:   |                    |  |
|    | F.             | Do you perform medical or surgical procedures at an office-based surgical suite?  | Yes 🗌 No 🗌         |  |
|    |                | If yes, provide entity and procedures in the space provided at the end of application.  |                    |  |

| G. | Do you provide medical professional services (including opinions or advice) via the internet or any telemedicine progr   | ram? Yes 🗌 No 🗌                                     |
|----|--|---|
|    | If yes, what percentage of your practice does this constitute?%  |   |
|    | i. Do you provide these services to patients in states outside your primary practice location?   | Yes 🗌 No 🗌  |
|    | If yes, please provide a list of those states:   |   |
| Н. | Do you provide services to any nursing home or correctional facility?  | Yes 🗌 No 🗌  |
|    | If yes, provide name of facility(ies) and the percentage of your practice these services constitute?   |   |
| I. | Do you currently staff or do you anticipate staffing an emergency department?  | Yes 🗌 No 🗌  |
|    | If yes, is the emergency department work required to maintain hospital staff privileges?   | Yes 🗌 No 🗌  |
|    | i. How many hours per month do you practice in the emergency department?   |   |
| J. | Do you have a collaborative agreement with any paramedicals*?  | Yes 🗌 No 🗌  |
|    | i. Are any of these persons involved in patient care/contact at facilities where you are not physically present?<br>These include, but are not limited to, nursing homes, correctional facilities, extended care facilities, and satellite o   | offices. Yes 🗌 No 🗌                                 |
|    | ii. Are any of these persons not in your employ?   | Yes 🗌 No 🗌  |
| No | $\dot{\mathbf{r}}$ This question applies only to physicians who are the only physician named on the policy.  |   |
| K. | Do you currently employ paramedicals other than those listed below?  | Yes 🗌 No 🗌  |
|    | Please mark any changes below, including any additional paramedicals:  |   |
|    |  | n or Termination Date<br>or additions or deletions) |
|    | [prefill w/parameds on policy]   |   |
|    | Paramedicals include a person practicing as a psychologist, nurse midwife, nurse anesthetist, nurse practitioner, physician's assistant, surge optometrist, cytotechnologist, emergency medical technician, anesthesiologist assistant, or any person licensed, certified, or otherwise authoriz health care in the absence of direct supervision by a licensed physician. |   |
| Ce | rtification  |   |

| А. | Are      | you board certified?   | Yes 🗌 No 🗌 |
|----|----------|--|------------|
|    | i.       | If yes, please indicate which board and specialty/subspecialty:                                  |            |
|    |          | American Board of:   |            |
|    |          | American Osteopathic Board of:   |            |
|    | <br>11.  | If not boarded, when do you plan to take your Boards?  |            |
|    | <br>111. | Are you required to recertify?   | Yes 🗌 No 🗌 |
|    |          | If yes, please provide date of recertification:  |            |
|    | iv.      | Have you failed a Board certification or recertification examination within the last five years? | Yes 🗌 No 🗌 |
|    |          | If yes, how many times?  |            |

### 5. Procedures

4.

A. Please review <u>each</u> section and check the procedures that apply to your practice. This information is used for rating purposes; the order in which the procedures are presented below does not represent rating classifications.

# Anesthesia, Physical Medicine, Rehabilitation/Pain Management Procedures

| Ш | Anesthesia (Check type and where administered)   | II       | Commissed Conitor  | 055                                |
|---|--|----------|--|------------------------------------|
|   | <ul> <li>Caudal</li> <li>Moderate (Conscious) Sedation</li> <li>General</li> <li>Spinal</li> </ul>   | Hospital | Surgical Suite   |                                    |
|   | Lumbar Puncture  |          |  |                                    |
|   | Pain Management         Medication Only         Spinal Cord Stimulators         Facet Blocks         Selective Nerve Root Blocks         Rhizotomy         Spinal Injections         Dorsal Root Gangliotomies |          | Thoracic Sympathect<br>Implantation/Remov<br>Sphenopalatine Lesio<br>Trigeminal Lesioning<br>Cordotomies<br>Other: | val of Drug Infused Pumps<br>oning |
|   | Trigger Point Injections   |          |  |                                    |

# **Procedures Continued**

| Radiology-Related Procedures         Fluoroscopy         Mammography         Myelography   | <ul> <li>Radiology – Interventional</li> <li>Radiation/X-ray Therapy</li> <li>Radiopaque Dye</li> </ul>   |          |
|--|---|----------|
| Cosmetic/Dermatological Procedures         Blepharoplasty         Botox Injections         Chemical Peels         Chemabrasion         Collagen Injections         Cryosurgery (superficial only)         Dermabrasion         Dermabrasion         Fat Transfer         Hair Transplants  | <ul> <li>Laser Hair Removal</li> <li>Laser Skin Resurfacing</li> <li>Laser Vein</li> <li>Lipodissolve/Mesotherapy</li> <li>Liposuction</li> <li>Microdermabrasion</li> <li>Sclerotherapy</li> <li>Silicone Injections</li> <li>Other:</li> </ul>  |          |
| <ul> <li>Circumcision (other than newborns)</li> <li>Colonoscopy</li> <li>Colposcopy</li> <li>Cryosurgery (other than external lesions)</li> <li>D&amp;C</li> <li>Endoscopic Laser Therapy</li> <li>Endoscopy other than Proctoscopy,<br/>Sigmoidoscopy, Colposcopy,<br/>and Cystoscopy</li> <li>ERCP/EGD/ERC</li> <li>Fracture Reductions</li> <li>Open</li> <li>Closed</li> <li>Haad Surgery</li> <li>Head and Neck Surgery</li> <li>Hemorrhoidectomy</li> </ul> | Hysterectomy         Hysteroscopy         Left Heart Catheterization         Obstetrics/Gynecology – Major Surgery         C-Sections Number Per Year:         Ophthalmology Surgery         Ophthalmology Surgery         Ophthalmology Surgery         Orthopedic – Major Surgery         Spines         No Spines         Otorhinolaryngology – Major Surgery         Including Elective Cosmetic Procedures         Penile Implants         Permanent Pacemaker         Plastic – Major Surgery         Robotic Surgery         Robotic Surgery         Robotic Surgery         Thoracic Surgery:% of Practice         Transgender Surgery         Trauma Surgery         Vascular Surgery:% of Practice         Vascular Surgery:% of Practice |          |
| <ul> <li>Angiography/Arteriography</li> <li>Breast Biopsy</li> <li>Chelation Therapy<br/>(for other than heavy metal poisoning)</li> <li>Echocardiography</li> </ul>   | v scope of practice within your specialty?  | ∏Yes ∏No |

iii. Do you perform any diagnostic or therapeutic procedures which have been introduced to the medical profession within the past two (2) years?

If yes, please provide the name of the procedures in the space provided at the end of this application.

Yes No

# I have noted below and agree to notify ProAssurance going forward of any the following events within thirty (30) days of its occurrence: (Please note any circumstances below under Additional Comments.)

- A. A change in my specialty or medical procedures performed;
- B. A change in my practice location, my provision of services to out-of-state patients, or telemedicine services;
- C. Complaint, grievance, investigation, restriction, suspension, or surrender of any state medical license, DEA license, or hospital privileges;
- D. Investigation of my Medicare/Medicaid billing procedures;
- E. Any physical or mental condition or illness, including treatment for alcohol or substance abuse or any accusation of sexual misconduct or inappropriate contact not previously disclosed to ProAssurance in writing;
- F. Conviction, plea, or agreement related to any charges of a misdemeanor or felony (including DUI, DWI, OUI) other than minor traffic offenses;
- G. A claim or suit for alleged malpractice has been made against me and reported to **another insurance carrier or hospital self-insured trust**, or any claim or suit resulted in payment by me or on my behalf, since I became an insured of a ProAssurance company.

I acknowledge that information concerning any of the events described above is material to the provision of insurance under the policy on the basis and for the premium stated in the Coverage Summary of the policy.

# Failure to notify ProAssurance of such changes could require retroactive upward premium adjustment and, in the event of a claim, could lead to denial of liability.

### 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): |       |  |
|-----------------|-------|--|
| Signature:      | Date: |  |

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage.

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

# Additional Comments

Please attach additional sheets as necessary.

#### **Current Certificate of Insurance Holders:**

(Please cross out any certificate holders that are no longer applicable, and use the additional lines to add other certificate holders to whom we should mail a Certificate.)

Include Name, Address, and Phone