

Applicant's Name _____

PRACTICE INFORMATION

Practice Name _____ Office Phone _____

Corporate Office Address _____ Office Fax _____

City _____ State _____ Zip Code _____

LICENSURE AND CERTIFICATION

I am applying for coverage as a:

- Certified Nurse Midwife Nurse Surgical Assistant Perfusionist Registered Nurse
 Nurse Anesthetist (CRNA) Occupational Therapist Physician Assistant Radiology Technician
 Licensed Practical Nurse Optician Psychologist Other: _____
 Nurse Practitioner (CRNP) Optometrist Physical Therapist _____

PA License Number (If applicable) _____ Additional Certifications _____

WORK SETTING/HOURS

Please check all that apply:

- Primary Physician Office Emergency Department Hospital Operating Suite Ambulatory Surgery Center
 Specialty Physician Office Trauma Center Hospital In-Patient Unit Other Outpatient Facility
 Psychiatric Facility Nursing Home/Extended Care Facility

Average worked hours per week: Please indicate the average total hours worked per week: (Worked hours includes patient care, hospital rounds, record keeping, administrative duties, teaching, house calls, nursing home visits and utilization review)

8 or less hours 16-20 hours 30 or more hours
 9-10 hours 21-24 hours
 11-15 hours 25-29 hours

SCOPE OF PRACTICE

Please check all that apply:

- Assist in surgery Pre or post operative care Emergency or critical care <10 hrs per week
 Diagnostic management Obstetrical care Emergency or critical care >10 hrs per week
 Ordering/interpreting diagnostic testing Prescribe medications After hours/weekend call
 Perform physical assessments Pediatric care _____
 Compile patient histories Anesthesia administration _____

CLASSIFICATION OF PHYSICIAN ASSISTANTS

If you are a physician assistant, which class best describes your duties:

Level 1	Performing tasks ordinarily reserved for a physician and assisting in the diagnostic management of patient's under the direction and supervision of a physician.	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Level 2	Assisting in surgery (general family practice or general surgery)	<u>Yes</u>	<u>No</u>	Less than 10 hours per week exposure to emergency department or trauma center care	<u>Yes</u>	<u>No</u>
	Assisting in anesthesiology	<u>Yes</u>	<u>No</u>	Assisting in anesthesiology	<u>Yes</u>	<u>No</u>
Level 3	Obstetrical exposure limited to pre-natal care or post-natal care	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
	Assisting in surgery (orthopedic, OB/GYN, cardiovascular, thoracic, neurosurgical, and/or plastic surgery)	<u>Yes</u>	<u>No</u>	greater than 10 hours per week exposure to emergency department or trauma center care	<u>Yes</u>	<u>No</u>
	Obstetrical care including deliveries	<u>Yes</u>	<u>No</u>	Work in a cardiac catheterization laboratory	<u>Yes</u>	<u>No</u>
	Personally handling after-hours or weekend calls	<u>Yes</u>	<u>No</u>	Working in a location separate from your supervising physician	<u>Yes</u>	<u>No</u>

How many physician assistants or nurse practitioners does your supervising physician have under a collaborative agreement? _____

Is a physician on-site and available to see patients while you are working, if needed? _____ **Yes** _____ **No**

Applicant's Signature _____ Date _____

Applicant's Name _____

HOSPITAL PRIVILEGES

Hospital Name	City, State	Type of Privileges	Specialty or Department

INSURANCE HISTORY

	Current Policy	First Prior Policy
Name of Carrier		
Type of policy	___ Claims-Made ___ Occurrence	___ Claims-Made ___ Occurrence
Effective date		
Expiration date		
Retroactive date		

COVERAGE REQUESTED

Type of coverage requested:

Limits of Liability requested:

___ Claims-Made Coverage

___ \$500,000 per claim/\$1,500,000 Annual Aggregate

___ Occurrence Coverage

___ \$1,000,000 per claim/\$3,000,000 Annual Aggregate*

* Certified Registered Nurse Practitioners and Physicians Assistants are required to obtain limits of \$1,000,000/\$3,000,000

PRIOR ACTS COVERAGE

If your prior policy is a "CLAIMS-MADE" policy, you must either purchase prior acts coverage through this policy or obtain an extended reporting period endorsement (tail) from your prior carrier.

If you DO NOT WANT or DO NOT NEED prior acts coverage, please indicate this decision by signing in the space provided. By signing, you are acknowledging that your retroactive date of coverage WILL BE THE SAME as your effective date of coverage.

I decline or do not need retroactive coverage

Applicant Signature

ADDITIONAL INFORMATION

Within the past seven (7) years have you been the subject of any complaint, charge or disciplinary action against you for any reason by a court, licensing board, hospital, or regulatory agency responsible for enforcing or maintaining the standards of your profession?	<u>Yes</u>	<u>No</u>
Have you ever had your professional liability insurance declined, cancelled or non-renewed for any reason?	<u>Yes</u>	<u>No</u>

Please provide a brief explanation for either question above:

Applicant's Signature _____

Date _____

Applicant's Name _____

PROFESSIONAL LIABILITY HISTORY

Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior or current insurer?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Has any claim or suit for alleged malpractice been brought against you in the prior ten (10) years?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Please provide a brief explanation for each situation which requires a "YES" answer to any of the prior three questions:

1.
2.
3.
4.

The undersigned agrees to fully comply with the conditions of membership in CPPRRG and understands that noncompliance may result in a non-renewal of coverage. The undersigned declares that to the best of his or her knowledge and belief that the statements set forth herein are true. Although the signing of this application does not bind the undersigned on behalf of the applicant or its organization or other insured person to effect insurance, the undersigned agrees that this application and its attachments shall be the basis of the contract should a policy be issued and shall be attached to and form part of this policy. The Company is hereby authorized to make any investigation and inquiry in connection with this application that it deems necessary.

Notice to Pennsylvania Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act which is a crime and subjects such a person to criminal and civil penalties.

The policy you are applying for will be 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 guaranty funds are not available for your risk retention group.

Applicant's Signature _____

Date _____