6455 EAST JOHNS CROSSING
SUITE 240
DULUTH, GA 30097
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PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY APPLICATION

SHORT FORM

APPLICANT INFORMATION

NAME OF APPLICANT: ______

PRIMARY MEDICAL SPECIALTY: ______

SUB-SPECIALTY: ______ | BOARD CERTIFIED YES ☐ NO ☐

STATE(S) IN WHICH YOU HOLD A LICENSE TO PRACTICE MEDICINE:

STATE	LICENSE NUMBER	STATE	LICENSE NUMBER

CHECK(✓) ALL SURGICAL/MEDICAL PROCEDURES YOU PERFORM AND ENTER APPROXIMATE NUMBER YOU PERFORM EACH MONTH WHERE INDICATED.

PHYSICIAN UNDERWRITING INFORMATION

ABDOMINAL SURGERY____ PER MO. ☐	C-SECTIONS PER MO. ☐	**PNEUMATIC OR MECH. ESOPHAGEAL DILATION** PER MO. ☐ WITH BOUGIE OR OLIVE CLIP ☐ WITHOUT BOUGIE OR OLIVE CLIP ☐
ABORTIONS ______ PER MO. ☐	DELIVERIES PER MO. ☐	PRE-NATAL CARE PAST FIRST TRIMESTER ☐
ACUPUNCTURE ☐	DILATION/CURETTAGE PER MO. ☐	RADIATION THERAPY ☐
ADENOIDECTOMIES PER MO. ☐	DISKOGRAPHY ☐	RADIOPAQUE DYE INJECT. (OTHER THAN IVP) THE BLOOD VESSELS LYMPHATICS, SINUS TRACTS/ FISTULAE ☐
AMNIOCENTESIS ☐	EGD ☐	SHOCK THERAPY (ECT/EST) ☐
ANGIOGRAPHY ☐ VENOUS ☐ ARTERIAL ☐ PERIPHERAL ANGIOPLASTY ☐	EKG ☐	THORACIC SURGERY PER MO. ☐
APPENDECTOMIES PER MO. ☐	ERCP ☐	TONSILLECTOMIES PER MO. ☐
ASPIRATIONS ☐	FLEXIBLE SIGMOIDOSCOPIES ☐	TRAUMA SURGERY PER MO. ☐
ASSISTANCE IN MAJOR SURGERY ☐ ON OWN PATIENTS ONLY ☐ ON PATIENTS OF OTHER ☐	FLUOROSCOPIC PROCEDURES ☐	TUBAL LIGATIONS ☐
BACK SURGERY ☐	HEMORRHOIDECTOMIES PER MO. ☐	VASCULAR SURGERY PER MO. ☐
BARIATRIC SURGERY PER MO. ☐ COSMETIC ☐ MEDICAL NECESSITY ☐	HERNIORRHAPHIES PER MO. ☐	VASECTOMIES ☐
BREAST IMPLANTS ☐	INJECT. OF IRRADIATED SUBSTANCES INTO BLOOD STREAM FOR DIAGN. PURPOSES (IVP) ☐	VENIPUNCTURES ☐
CARDIAC CATHETERIZATION ☐	LAPAROSCOPIC CHOLECYSTECTOMIES PER MO. ☐	OTHER SURGERIES/NO. PER MO. ☐
DIAGONOSTIC CORONARY ANGIOGRAPHY ☐	LAPAROSCOPIC LASER SURG. PER MO. ☐	______
LEFT HEART CATHETERIZATION ☐	LAPAROSCOPY (PERITONEOSCOPY) ☐	______
PERMANENT PACEMAKER ☐	LASER USED IN THERAPY ☐	______
PTCA (CORONARY ANGIOPLASTY) ☐	LIPOSUCTION________ PER MO. ☐	LIST OTHER ENDOSCOPIES ☐
CARDIAC SURGERY PER MO. ☐	LUMBAR PUNCTURE ☐	______
CAST (SET) ☐	LYMPHANGIOGRAPHY ☐	______
CHOLECYSTECTOMIES PER MO. ☐	MYELOGRAPHY ☐	ADMINISTER OR SUPERVISE ANESTHESIA ☐
CIRCUMCISIONS (OTHER THAN NEWBORN) ☐	PHLEBOGRAPHY ☐	______
CLOSED RED. OF FRACTURES ☐	NEO-NATAL INTENS.CARE VISITS P/M ☐	______
COLONOSCOPIES/SUIGMOIDOSCOPIES ☐	OPEN REDUCTIONS PER MO. ☐	______
CRYOSURGERY ON MALIG. LESIONS ☐	ORTHOPEDIC SURGERY PER MO. ☐	
CT SCANNING NO DYE ☐ WITH DYE ☐		

PHYSICIAN UNDERWRITING INFORMATION (CONTINUATION)

1. Has your license to practice medicine or your permit to prescribe drugs, or your hospital staff privileges ever been denied, revoked, suspended, placed on probation, subjected to reprimand, voluntarily surrendered or in any other way limited, or has it been or is it currently under investigation?__________ YES ______ NO

   ____
   ____
   ____

2. Has any insurance company ever canceled, declined to issue or refused to renew your professional liability insurance.
   ______ YES ______ NO

   ____
   ____
   ____

3. Has any civil or criminal action ever been filed against you or have you been notified that any civil action will be filed against you alleging professional errors or omissions?______ YES ______ NO Have any judgments been made against you, or any out-of-court settlements been made on your behalf, from an incident alleging medical errors or omissions?
   ______ YES ______ NO

   ____
   ____

4. Have you ever been treated or evaluated for alcoholism or drug addiction, psyschiatric / psychological treatment or evaluation, Have you received any major medical / surgical treatment or evaluation for illness or accident ______ YES
   ______ NO

   ____
   ____

FOR ANY YES ANSWER, ATTACH DETAILS WHERE APPLICABLE

IMPORTANT AUTHORIZATION RELEASE

I understand that this is an application for insurance and not an insurance binder. I also understand that, if my application is approved, my effective date cannot be prior to the date that I have met all of the Company's requirements for issuance.

X______________________________ ______________________________

Applicant's Signature (required) **Date**