Allied Health Care Provider Application

PA (Physician Assistant) & NP (Nurse Practitioner)

Indicate if: ☐ **Claims Made** **OR** ☐ **Occurrence Coverage Desired**

SECTION I. IDENTIFYING INFORMATION		
Applicant Name (Last, First, Middle)		
Date of Birth	Phone Number	Email Address
Prof. Designation	License No.	Solo Corporation *(if applicable)*
Primary Office Address		
Mailing Address		

SECTION II. COVERAGE INFORMATION

Requested Effective Date of Coverage MM _____ DD _____ YYYY _____ 12:01 am Local Time

Requested Retro Date of Coverage *(Only for Claims Made Coverage)* MM _____ DD _____ YYYY _____ 12:01 am Local Time

Please Identify Your Position

❍ Employee ❍ Independent Contractor ❍ Other (please specify) _____

Indicate Limits Desired

Each Claim _____ Annual Aggregate _____

SECTION III. PRACTICE LOCATION

Name of Practice	Street	State	Zip	Location Type *(Office, Surgery Center)*

SECTION IV. PRACTICE INFORMATION

Average weekly practice hours for which coverage is desired:

Please indicate ALL that apply to your current professional practice

☐ Hospital (Inpatient Unit)	☐ Med Spa/Day Spa	☐ Nursing Home/ LTC
☐ Hospital (Outpatient Unit)	☐ Psychiatric Facility	☐ Home Health Care
☐ Urgent Care Facility	☐ Surgi-Center	☐ Family Practice
☐ Trauma Center	☐ School/Health Department	☐ Specialty/Physician Office/Facility
☐ OR Cardiovascular/Thoracic, Neurological, OB/GYN, Plastic Surgeon	☐ ER > 10 hours/week	☐ Emergency Unit
☐ OR - All Other/Identify	☐ ER < 10 hours/week	☐ Trauma Center
☐ Family General Medicine	☐ Correctional Facility	☐ Surgi-Center
☐ Emergency Medicine	☐ Psychiatric	☐ Neurological
☐ Orthopedics	☐ OB - *If YES, please complete questions listed below*	☐ Plastic Surgery
☐ Cardiovascular/Thoracic	☐ GYN	☐ Assisting in Surgery
☐ Cosmetic/Aesthetics	☐ Dermatology	☐ Anesthesia Administration

OBSTETRICS

Obstetrics defined as the care and treatment of pregnancy including, but not limited prenatal care, labor, delivery, cesarean section and/or postnatal care.

1. **If you practice Obstetrics please check all that apply:**
   - **a.** ☐ First Trimester Prenatal Care
   - **b.** ☐ Second Trimester Prenatal Care
   - **c.** ☐ Third Trimester Prenatal Care
   - **d.** ☐ Deliveries (estimated number per year)
   - **e.** ☐ Cesarean Section
   - **f.** ☐ Other (specify)
2. **Do you take Obstetrics calls?**
   - **a.** ☐ YES - Please explain _____
   - **b.** ☐ NO
3. **Do you provide professional health care services (not limited to OB care) during delivery (including the immediate labor, puerpenum and/or neonatal period) in any facility or any place other than a licensed acute care hospital?**
   - **a.** ☐ YES - Please explain _____
   - **b.** ☐ NO
4. **Do you perform interpret ultrasounds?**
   - **a.** ☐ YES - Please explain _____
   - **b.** ☐ NO
5. **Do you order, prescribe or dispense any controlled substances? If you do, please provide federal DEA license information.**

   License Number _____ Status _____ Expiration Date _____
   - **a.** ☐ YES - Please identify the level(s)
     - **i.** ☐ Schedule I
     - **ii.** ☐ Schedule II
     - **iii.** ☐ Schedule III
     - **iv.** ☐ Schedule IV
     - **v.** ☐ Schedule V
   - **b.** ☐ NO

SECTION V. SUPPLEMENTAL QUESTIONS

If you answer YES to any one of the following questions, you must provide a detailed written narrative (including, but not limited to, date of occurrence, reason for occurrence and resolution) and pertinent documentation (e.g., nonrenewal or declination notice, medical board documents, letters from hospital, diversion program, treating physician, etc.).

1. Has any professional liability insurance company **ever** canceled, non-renewed or modified (e.g., involuntarily reduced limits, restricted coverage, added a deductible and/or surcharge, etc.) your insurance, declined to offer you coverage or notified you of its intent to pursue such action? ☐ Yes ☐ No

2. Has your license to practice as a health care professional in any jurisdiction, your DEA registration, or any applicable controlled substance license or registration in any jurisdiction ever been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, fined, subject to probationary terms or conditions or otherwise investigated or limited in any way? ☐ Yes ☐ No

3. Has any governmental agency ever investigated you, placed you on probation, suspended you or taken any action against you? ☐ Yes ☐ No

4. Have your clinical privileges, memberships, contractual participation in or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, subject to probationary terms or conditions or otherwise investigated or limited in any way for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? ☐ Yes ☐ No

5. Have you **ever** surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges with; terminated contractual participation or employment in; or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence, improper professional conduct or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? ☐ Yes ☐ No

6. Have you **ever** been convicted of or admitted to committing a misdemeanor, including a DUI, but excluding minor traffic violations? ☐ Yes ☐ No

7. Have you **ever** been charged with, been convicted of or admitted to committing a felony? ☐ Yes ☐ No

8. Have you **ever** been accused of sexual misconduct? ☐ Yes ☐ No

9. Have you **ever** had any contact of a sexual nature with a patient or a former patient? ☐ Yes ☐ No

10. Have you **ever** had a problem with, been evaluated for, been diagnosed with, been treated for or are currently being treated for alcohol, narcotic or any other substance addiction, sexual addiction or mental illness? ☐ Yes ☐ No

11. Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice? ☐ Yes ☐ No

SECTION VI. CLAIMS INFORMATION

1. **Within the past seven (7) years has a** malpractice claim or suit been brought against you, or have you been notified of your involvement in a malpractice claim or suit, either directly or indirectly? ☐ Yes ☐ No

2. To your knowledge, within the past seven (7) years has a malpractice claim been brought against any organization (e.g., medical group, hospital, etc.) as a result of your rendering or failing to render professional health care services? ☐ Yes ☐ No

3. Are you aware of any medical incident or accident, conduct, circumstance or occurrence that might reasonably be expected to give rise to a claim or suit against you, directly or indirectly, even if you believe the claim or suit would be without merit? ☐ Yes ☐ No

If you answered yes to questions 1, 2 or 3, please complete a Claim Information Form for each applicable claim, suit, incident, conduct, etc.

REPRESENTATIONS, WARRANTIES AND AUTHORIZATION TO RELEASE INFORMATION

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my coverage. I agree to notify PMSLIC Insurance Company immediately if my practice changes in any way and of any change in the information contained in this questionnaire.

I authorize the release and exchange of information between PMSLIC Insurance Company and its authorized representatives and my past and present medical group(s), association(s), society(ies) and their insurance agents, brokers or consultants; any hospital or other health care facility or organization where I presently hold, am applying for or previously held staff privileges or panel membership; prior and current insurance carriers; government agencies; educational institutions and any other entities or individuals PMSLIC deems necessary. I understand PMSLIC, at its discretion, may obtain background information to aid in its evaluation of my insurability. I agree that the individual or organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I further agree to hold harmless and release PMSLIC, its agents and representatives, from any liability arising from any exchange of information about me.

Signature

Date *(mm/dd/yyyy)*