Professional Extender Application for Limited Medical Malpractice

Checklist:

Along with the completed Application,
please provide copies of the following documentation:

☐ Most current C.V. / Resume

☐ Practitioner Certificate

☐ Current Medical License

Return Application and requested documentation to:

Physicians Indemnity Risk Retention Group, Inc.

Email: info@pirrg.com
Facsimile: 888.608.6327

Please call 813-513-3041 with any questions or concerns.

DOCTORS' ARMOR
by Physicians Indemnity

Professional Extender Application for Limited Medical Malpractice

Although not all questions may be application to you, please do not leave any question(s) unanswered. Write NONE or N/A when the question does not apply to you.

Requested Effective Date: _____ Years in Practice: _____

Name: _____ PA ☐ NP ☐ SA ☐ CNM ☐ CRNA ☐

Office Address: _____

Ofc Phone: _____ Ofc Facsimile: _____ Cellular: _____

Medical License: State _____ License # _____ Expiration _____

Number of Hours Worked: _____ Number of Patients Seen Per Week: _____

I am an employee of _____ Policy No: _____
(Supervising Physician's Name)

Limits of Liability ***(Must have same limits of liability as Supervising Physician)***

☐	$250,000 / $750,000	☐	$500,000 / $1,500,000	☐	$1,000,000 / $3,000,000
☐	SHARED Limits of Liability with Supervising Physician (No additional cost. Tail coverage not available)				
☐	SEPARATE Limits of Liability from Supervising Physicians (Additional cost. Tail coverage available)				

Please note that ARNP's must also have a miniumum of $250,000 / $750,000 coverage. Shared limits coverage of $250,000 / $750,000 between a physician and ARNP is not suggested as both parties may fall below the state minimum. See Florida Statute 458.320 and Chapter 64B8-12 for additional information.

		Yes	No
1.	Have you ever:		
	a) Been convicted of a crime, other than traffic violation(s)?	☐	☐
	b) Suffered from or been treated for substance abuse, mental illness or serious physical condition(s)?	☐	☐
	c) Had a complaint filed against you with your State Regulatory Board?	☐	☐
	d) Had any professional license / permit or narcotics license investigated, suspended, revoked, restricted or placed under probation?	☐	☐
	e) Been warned about your performance or placed any type of probation during your training?	☐	☐
2.	Have you ever been involved in a malpractice claim, lawsuit or incident?	☐	☐
3.	Has any insurance carrier denied, surcharged, rated-up, restricted, cancelled, or refused to renew your medical malpractice insurance coverage?	☐	☐
4.	Will you work at a location or during a time where there will be no supervising physician present?	☐	☐
	If yes, please explain:		

5.	Do you elicit, record, and evaluate a patient's health, psychosocial and development history.	☐	☐
6.	Does your practice comply in every way with the rules, regulations, guidelines, and standards as set forth by your State Regulatory Board?	☐	☐
7.	Do you perform physical examinations?	☐	☐
	If yes, please describe the techniques and instruments used.		
8.	Do you order or perform appropriate diagnostic tests?	☐	☐
9.	Do you discriminate between normal and abnormal findings on the history, physical examination, diagnostic tests, and initiate referral and consultation when appropriate?	☐	☐
10.	Do you regulate or adjust medications and treatment as prescribed or authorized by a licensed physician?	☐	☐
11.	Describe any other procedures, treatments, or duties that you perform. If none, please write "N/A."		

Applicant's Authorization and Certification

I authorize the release of all information to PIRRG from:

1. Any hospital at which I have applied for privileges, whether said privileges were granted or not.
2. Any state regulatory body granting me a license to practice medicine.
3. Any insurance company to which I have applied for medical malpractice coverage, whether said coverage was granted or not.
4. Any employer for whom I performed medical services.

I understand that information requested by PIRRG will also include, but not necessarily be limited to:

1) Any incident, claim, or lawsuit in which I may, or may not, be involved with.
2) Underwriting matters from my past and/or present state licensing board.

I also authorize PIRRG to release any such information, as well as any and all information which PIRRG may have, to any committee of a professional association or society, or any subcommittee or section thereof, formed for the purpose of providing services to PIRRG pursuant to any agreement entered into between them, including consultation and advice with respect to underwriting review, claims review, loss prevention, physician counseling and related services.

I understand that this is an application for insurance, not an insurance binder.

The undersigned hereby applies to Physicians Indemnity Risk Retention Group (PIRRG) for a reporting policy. The undersigned has read the Policy and understands that such coverage is subject to Underwriting approval. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recover under the policy issued, unless they are fraudulent, material either to the acceptance of risk, or to the hazard assumed by PIRRG, or if PIRRG, in good faith, would either not have issued the policy, or would not have issued a policy in as large an amount, or would have not provided coverage with respect to hazard resulting in the loss, if the true facts have been made known to PIRRG as required by the application for the policy or otherwise.

Applicant's Signature		Date:
Printed Name		
Supervising Physician's Signature		Date:
Printed Name		