Professional Extender Application for Limited Medical Malpractice Coverage

Although not all questions are applicable to you, please do not leave any questions 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
(Last, First, Middle Initial) (Circle one)

Office Phone: _______________________ Fax: ________________________ Cell: _________________________

Office Address: ____

Medical License: State: __________ License #: _______________ Expiration: ____________

Number of hours per week: ____________ Number of patients seen per week: ____________

I am an employee of ____ Policy #: ____________________
(Supervising Physician's Name)

Limits of Liability (**<u>Must have same limits of liability as supervising physician</u>**):

_____ $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 Physician (Additional cost. Tail coverage available to purchase)

Please note that ARNPs must also have a minimum of $250,000 / $750,000 coverage. Shared limits coverage of $250,000/$750,000 between a physician and ARNP is <u>not</u> suggested as both parties may fall below the state minimum. See F.S. 458.320 and Chapter 64B8-12.

1) Have you ever:
   a) been convicted of a crime, other than traffic violation? ___ Yes ___ No
   b) suffered from or been treated for substance abuse, mental illness or serious physical condition? ___ Yes ___ No
   c) had a complaint filed against you with your State Regulatory Board? ___ Yes ___ No
   d) had any professional license/permit or narcotics license investigated, suspended, revoked, restricted or placed under probation? ___ Yes ___ No
   e) been warned about your performance or placed on any type of probation during your training? ___ Yes ___ No

2) Have you ever been involved in a malpractice claim, suit or incident? ___ Yes ___ No

3) Has any insurance carrier ever denied, surcharged, rated-up, restricted, cancelled, or refused to renew your medical malpractice insurance? ___ Yes ___ No

4) Will you work at a location or during a time where there will be no supervising physician present? ___ Yes ___ No

If the answer to any of the above is "YES" please explain on an additional page.

5) Do you elicit, record, and evaluate a health, psychosocial and developmental history of the patient? ___ Yes ___ No

6) Does your practice comply in every way with the rules, regulations, guidelines, and standards as set forth by your State Regulatory Board? ___ Yes ___ No

7) Do you perform a physical examination? If "YES" briefly describe techniques and instruments used. ___ Yes ___ No
____
____

8) Do you order or perform appropriate diagnostic tests? ___ Yes ___ No

9) Do you discriminate between normal and abnormal findings on the history physical examination, diagnostic tests, and initiate referral and consultation when appropriate? ___ Yes ___ No

10) Do you regulate or adjust medications and treatment as prescribed or authorized by a licensed physician? ___ Yes ___ No

11) Describe any other procedures, treatments, or duties that you perform, if none 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 those privileges were granted or not.
2. The regulatory body granting me a license to practice medicine in any State.
3. Any insurance company to which I have applied for medical malpractice coverage, whether such 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 suit in which I may be or may have been involved.
2. Underwriting matters from my past and 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 an 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 recovery under this policy issued, unless they are fraudulent, material either to the acceptance of risk, or to the hazard assumed by the Company, or if the Company 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 the Company as required by the application for the policy or otherwise. I also certify that I have read the attached "restrictions applying to additional insured coverage."

Signature of applicant: ____

Printed Name: ____

Signature of Insured: ____

Printed Name:____ **Date:** __________________

Return only fully completed application to PIRRG by fax (888) 608-6327
For questions call us at (813) 513-3041

*****BE SURE TO INCLUDE A COPY OF YOUR CV, PRACTITIONER CERTIFICATE, AND CURRENT MEDICAL LICENSE TO ENSURE TIMELY PROCESSING OF YOUR APPLICATION FOR COVERAGE*****