CROUSE AND ASSOCIATES
License #0805281

PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY APPLICATION (CLAIMS MADE COVERAGE)

1. **Full Name of Applicant:**

2. **Principal Office Address:**
   County:

3. **Home Address:**

4. **Social Security #:** **DEA #:**

5. **List the States and License Numbers where you practice:**

6. **Date of Birth:** **Place of Birth:**

7. **Are you a U.S. Citizen?** ☐ **Yes** ☐ **No If NO, please indicate your status and date of entry into the United States:**

8. **What is your medical or surgical specialty:**
   What percentage of your practice is dedicated to this specialty?

9. **What is your sub-specialty:**
   What percentage of your practice is dedicated to this specialty?

10. **Do you limit your practice to the above specialties?** **Yes** **No If No, what other specialties do you practice? Provide details.**

11. **Are you American Board certified?** ☐ **Yes** ☐ **No**
    Medical Specialty: **Date Certified:**
    Medical Specialty: **Date Certified:**

12. **Type of Practice (check all that apply)**
    ☐ **Individual** ☐ **Employee** ☐ **Member of Multi-person Corp or Assoc**
    ☐ **Individual Corporation** ☐ **Partnership** ☐ **Other**

13. **What is your total annual revenue?**
    ☐ **$100,000 or less** ☐ **$250,001-$499,999**
    ☐ **$100,001 - $250,000** ☐ **$500,000 or more**

14. **Please provide the names of all facilities that you practice at and your interest in each facility.**

Name of Clinic or Facility and Location	Interest (Owner, Partner, Employee?)

***Attach a separate attachment if necessary.**

15. **Are you seeking coverage for your work at all of the above facilities?** ☐ **Yes** ☐ **No If No, please list those facilities for which you do not require coverage and explain why coverage isn't needed.**

16. **Please provide the number of professionals you employ or contract with and whether or not they carry their own individual medical malpractice coverage.**

	Employed	Contracted	Carry their own Med Mal policy?
Physicians	_____	_____	____ Yes ____ No
Physicians Assistants	_____	_____	____ Yes ____ No
Nurse Practitioners	_____	_____	____ Yes ____ No
Surgical Technicians	_____	_____	____ Yes ____ No
CRNA's	_____	_____	____ Yes ____ No
Chiropractors	_____	_____	____ Yes ____ No
RN's	_____	_____	____ Yes ____ No
LPN's, Nurse Aides	_____	_____	____ Yes ____ No
Other: _____	_____	_____	____ Yes ____ No
Other: _____	_____	_____	____ Yes ____ No

***Please attach copies of dec pages on above professionals that carry their own malpractice policies.**

17. **Are all of the above individuals licensed in accordance with applicable state and federal regulations?**
_____ Yes _____ No If NO, please attach explanation.

18. **List the hospitals at which you are currently a staff member:** _____
_____
_____

19. **Briefly describe the type and extent of your hospital privileges:** _____
_____

20. **Are you the Chief or Head of a hospital department? _____ Yes _____ No If YES, which department(s):**
_____

21. **Are you the medical director of a nursing home or assisted living facility? If so, please provide the name of the facility:**
_____

22. **Are you the medical director of any other facilities? If so, please provide the names of each facility:**
_____
_____

23. **From what Medical School did you graduate?** _____
City, State and Country of Medical School _____
Degree: _____ **Year of Graduation:** _____
If foreign medical school graduate, are you certified by the Educational Council for Medical School Graduates? _____ Yes _____ No. If YES, state the year: _____

24. **Internship? _____ Yes _____ No If Yes, complete the following:**
Location: _____ **Dates: From** _____ **To** _____
Type: _____ **Completed? _____ Yes _____ No**

25. **Residency? _____ Yes _____ No If YES, complete the following for each:**
Location: _____ **Dates: From** _____ **To** _____
Type: _____ **Completed? _____ Yes _____ No**
Location: _____ **Dates: From** _____ **To** _____
Type: _____ **Completed? _____ Yes _____ No**

26. **Where have you practiced your profession since completion of training:**
In _____ **From** _____ **To** _____
In _____ **From** _____ **To** _____
In _____ **From** _____ **To** _____

27. **Additional Medical Training? _____ Yes _____ No If Yes, provide details including type, location, and date of training:** _____

_____

28. **Have you participated in any continuing medical education program(s) within the past five years? _____ Yes _____ No If YES, please provide details:** _____

_____

29. **Indicate memberships in professional societies:** _____

_____

_____

30.	Do you perform one or more of the following:	Yes	No
A.	Endoscopic Procedures, other than sigmoidoscopy or proctoscopy. If Yes, describe: _____ _____	_____	_____
B.	Catheterization, other than swan-ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel. If Yes, describe: _____ _____	_____	_____
C.	Arteriography, lymphangiography, myelography or phenmoencephalography?	_____	_____
D.	Interventional radiology-percutaneous transluminal angioplasty or embolization?	_____	_____
E.	Radiation therapy, including radium implants? If Yes, describe: _____	_____	_____
F.	Chemobrasion or dermabrasion?	_____	_____
G.	Hair Transplantation or Suturing of Hairpieces?	_____	_____
H.	Mohs Micrographic surgery? If YES, describe: _____	_____	_____
I.	Acupuncture? If YES, describe: _____	_____	_____
J.	Prenatal care and normal deliveries? If YES, Do you perform home deliveries? Do you only perform prenatal care? Do you supervise nurse midwives? If YES, when do you refer: _____ weeks gestation	_____ _____ _____ _____	_____ _____ _____ _____
K.	Dilation and curettage?	_____	_____
L.	Needle Biopsies? If YES, describe: _____	_____	_____
M.	Electroshock therapy or hypnosis? If YES, describe: _____	_____	_____
N.	Radial keratotomy, excimer laser PRK, LASIK or any other surgical vision correction procedure?	_____	_____

Do you perform any of the following? (continued)	Yes	No
O. Surgery, other than incision of boils and superficial abscesses or suturing skin and superficial fascia? If Yes, please attach a list of all surgical procedures.	☐	☐
P. Non-spontaneous, induced abortions? If YES, What is maximum trimester?_____	☐	☐
Q. Vasectomies or reversal of vasectomies?	☐	☐
R. Hysterectomies? If YES, do you perform laparoscopic hysterectomies?	☐ ☐	☐ ☐
S. Cholecystectomies? If YES, do you perform laparoscopic cholecystectomies? If YES, how many performed as of this date: _____	☐ ☐	☐ ☐
T. Tonsillectomies and/or Adenoidectomies?	☐	☐
U. Caesarian sections?	☐	☐
V. Spinal Surgery? If you also perform chemonucleolysis, check here: ☐ and/or percutaneous lumbar disectomy, check here: ☐	☐	☐
W. Administration of general, spinal or caudal block anesthesia?	☐	☐
X. Open reduction of fractures?	☐	☐
Y. Organ transplantation? If YES, describe: _____ _____	☐	☐
Z. Sex Change Operations?	☐	☐
AA. Weight Reduction Surgery including gastric bypass or other stomach banding procedures? If YES, which procedures? _____ _____	☐	☐
BB. Experimental research, surgical research, or experimental therapy in human patients? If YES, describe:_____	☐	☐
CC. Cosmetic/Plastic Surgery? If YES, complete the following: Do you perform breast augmentation? Do you perform breast reductions? Do you perform liposuction? If YES, what is the maximum amount of cc's removed? _____ Do you perform fat recycling? If YES, in what parts of the body? _____ Do you perform vaginoplasty or labiaplasty? Do you use silicone implants? If Yes, in which parts of the body: _____ Do you perform Botox injections? If Yes, in which parts of the body: _____	☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐
DD. Penile lengthening or enhancement procedures?	☐	☐

Do you perform any of the following? (continued) **Yes** **No**

EE. Any other surgical procedures not shown above? _____ _____
Please describe._____
_____

***PLEASE ATTACH A LIST OF ALL SURGICAL PROCEDURES YOU PERFORM**

31. Do you perform surgery in your office? _____ Yes _____ No If YES, please list. _____
_____
_____

32. Do you perform surgery in other non-hospital facilities? _____ Yes _____ No (If YES, what type of facility and list the surgical procedures: _____
_____

33. In the course of surgery does a Board Certified Anesthesiologist provide the anesthesia? _____ Yes _____ No
If No, please provide details. _____
_____

34. Do you do any hospital emergency room work? _____ Yes _____ No If YES, Is the emergency room care:
Only for your own patients? _____ Yes _____ No
Required for staff privileges? _____ Yes _____ No
How many hours per month: _____
Does the hospital cover you for malpractice while you work in the emergency room? _____ Yes _____ No
Are you requesting coverage for your emergency room work? _____ Yes _____ No

35. Do you assist in surgery:
On your own patients? _____ Yes _____ No
On patients of others? _____ Yes _____ No

36. If your practice includes plastic surgery, specify the percentage of your practice devoted to:
_____% Traumatic Surgery _____% Cosmetic/Elective Surgery

37. If your practice includes weight reduction/control (other than by diet and exercise), specify the percentage of patients that are exclusively weight control: _____%.
Do you prescribe any weight control drugs? _____ Yes _____ No If YES, list drugs prescribed. _____
_____
_____
Do you dispense supplements for weight control? _____ Yes _____ No If Yes, list supplements dispensed. ___
_____
_____
Do you use injections for weight control? _____ Yes _____ No If YES, list drugs injected:_____
_____

38. Have you or any of your employees: (If yes, attach details.) **Yes** **No**

A. Ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association? Attach a copy of Complaint and Consent Order document if applicable. _____ _____

B. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? _____ _____

Have your or any of your employees? (continued)	YES	NO
C. Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required you be evaluated for an alleged mental condition and/or alcohol or drug addiction?	____	____
D. Ever had any state profession license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?	____	____
E. Ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms?	____	____
F. Ever failed any medical licensing or specialty organization examination?	____	____
G. Do you have any chronic illnesses or defects? If Yes, please describe. _____	____	____

39. Do you supervise any individuals other than your own employees? ____ Yes ____ No If YES, please provide detailed explanation of your responsibilities, relationship and whether or not these individuals have their own medical malpractice coverage: _____

_____

_____

40. Are you under contract to any individual, firm or corporation other than your own? ____ Yes ____ No <u>If YES, attach explanation including details of responsibilities. If this contract contains a hold harmless agreement then attach a copy of the contract language.</u>

41. Are you in the employ of, or under contract to any governmental entity? ____ Yes ____ No If YES, please provide details and outline your duties._____

_____

42. Do you offer professional advice to the public such as through a website, radio or TV broadcasts, newsletters, etc? ____ Yes ____ No If YES, please provide details. _____

_____

43. Do you advertise your professional services in any manner other than a simple listing in a telephone directory? ____ Yes ____ No If YES, please provide details and attach copies of all advertising brochures.

_____

_____

44. Are you associated with any agency or organization that engages in any kind of advertising for, or solicitation of patients? ____ Yes ____ No If YES, please provide details. _____

_____

45. Average Weekly Patient Load: _____ Total Patients Annually: _____
Total surgeries performed annually: _____

46. Average number of hours worked per week: _____

47. Do you anticipate any changes in your practice? ____ Yes ____ No If YES, please describe: _____

_____

_____

48. **List the prior medical malpractice insurance carried for each of the past 5 years beginning with most current:**

INSURANCE COMPANY	LIMITS OF LIABILITY	POLICY PERIOD	PREMIUM	RETRO DATE

***Attach a copy of the declarations page of your most recent policy.**

49. **Do you own, operate or provide professional services for, or at, any health care facility or business enterprise not already clearly described in this application? _____ Yes _____ No If YES, please describe: _____**

_____

50. **Has any claim or suit for alleged malpractice been brought against you?_____ Yes _____ No**
If YES, how many total claims or incidents: _____
Please complete the Supplemental Claim Information Form attached to this application for each and every claim. Also, please attach 10 years of currently valued company loss runs.

51. **Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer? _____ Yes _____ No If Yes, please complete the Supplemental Claim Information Form attached to this application for each and every claim.**

52. **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? _____ Yes _____ No If Yes, please provide details including name of claimant, date of occurrence, date of first contact, allegation and current status of incident.**

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made a part of the policy. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

_____ _____
Signature of Applicant **Date**

Please attach the following documents to this application:

- **C.V. or resume**
- **Five years of currently valued company loss runs**
- **Copies of any disciplinary actions, stipulation orders or probation documents**
- **Copies of declarations pages for all employees or contractors that carry their own med mal**
- **Copy of applicant's most current declarations page**

SUPPLEMENTAL CLAIM INFORMATION FORM
(Complete one form for each claim)

1. **Name of applicant/named insured:** _____
   _____
2. **Name of other parties or defendants named in suit:** _____
   _____
   _____
3. **Date of alleged error or occurrence, or contact date:** _____
4. **Date claim was made:** _____
5. **Name of claimant:** _____
6. **Name of Insurance Company handling your claim:** _____
7. **Present status of claim or final disposition:** _____
   _____
   _____
   Circle One: CLOSED OPEN
8. **Defense costs paid to date inclusive of any deductible:** _____
9. **If closed, total loss paid, inclusive of any deductible:** _____
10. **If claim is open or pending, what are the insurers reserves?**
    Defense: _____ **Loss:** _____
11. **Description of case and events including allegations and assessment of liability:** _____
    _____
    _____
    _____
    _____
    _____
12. **Claimants last settlement demand:** _____

_____ _____
Date **Signature**