Physicians Insurance
A MUTUAL COMPANY

VOLUNTEER / RETIRED PROVIDER PROGRAM
CLAIMS-MADE PROFESSIONAL LIABILITY APPLICATION

Please answer *all* questions, then sign and return the application to: Western Washington AHEC, 1201 Monster Road SW, Suite 440 Renton WA 98057

Applicant Name: _____

Professional Designation: _____

Gender: ☐Male ☐Female

Date of Birth: _____

Social Security Number: _____

E-mail Address: _____

Home Address: _____

Primary Phone Number: _____

Practice and Rating Information

Date volunteer service begins: (MM/DD/YYYY) _____

Clinic Name at which you will be volunteering:
(Must be a VR-approved clinic site) _____

Specialty in which you will practice: _____

History

WA Medical License Number: _____

Board Certification: Specialty: _____ Month/Year Issued: _____

1. Will you receive any compensation for your volunteer services? ☐Yes ☐No
2. Are you a student? ☐Yes ☐No
3. Is your volunteer service in Washington State at a VR approved site? ☐Yes ☐No
4. Are you only providing non-invasive services? ☐Yes ☐No

Professional Profile Questions:

1. Have any complaints **ever** been filed against you with a governmental agency, medical or professional society, or other medical entity? ☐Yes ☐No

2. Have you **ever** been subject to a governmental agency, medical or professional society, or other medical entity's disciplinary proceedings or reviews, or have you ever been notified of intent to pursue such action? ☐Yes ☐No

3. If "Yes," did the proceedings or review result in reprimand, censure, sanction, or modification or your practice, either voluntary or involuntary, or are you currently the subject of an administrative proceeding or review by such agency or society?

   ☐Yes ☐No

4. Have you **ever** been convicted for an act committed in violation of any law or ordinance other than traffic offenses?

   ☐Yes ☐No

5. Has any professional liability insurance carrier **ever** declined, cancelled, refused renewal, or issued coverage on special terms (premium surcharge, deductible, etc.), or have you ever been notified of impending action of this nature?

   ☐Yes ☐No

6. Have you **ever** been diagnosed with, been treated for, or are currently being treated for alcoholism and/or chemical dependency? ☐Yes ☐No

7. Has **any** claim or suit for alleged malpractice **ever** been brought against you or your professional corporation?

   ☐Yes ☐No

If "Yes," give full details for ALL claims even if closed for no payment. Attach separate sheet if necessary.

Date of Incident: _____

Patient Name: _____

Amount Paid: $ _____

Allegation:

For any negative responses, please explain in the box below:

AUTHORIZATION AND RELEASE (PLEASE READ CAREFULLY)

I acknowledge that as a condition precedent to acceptance of this application and any future renewal thereof, an inquiry and investigation of my professional background, qualifications and competence, including such other underwriting or claim matters as are deemed relevant, may be conducted by Physicians Insurance or its duly authorized representatives. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, their insurance consultants or agents, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any of my attending or treating physicians, the Washington Physicians Health Program, any prior insurance carriers, prior employers or professional associates and Physicians Insurance or its duly authorized representatives. I hereby release and discharge the providers of information, Physicians Insurance, its duly authorized representatives and the members or consultants of any established peer review committees from any and all legal liabilities which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by Physicians Insurance or its duly authorized representatives. I agree to notify Physicians Insurance immediately, in writing, if there are any changes from which I have described in this application, including changes in my practice, in my partners or associates, medical license, professional office premises, practice locations, medical procedures or administrative responsibilities and hospital privileges. I understand that Physicians Insurance does not cover any liability of another person or organization with whom I assume an oral or written contract or agreement.

_____ _____

Authorized Signature Date

(Signature Required)

A photocopy of this Authorization shall be considered as effective and valid as the original

For Washington, state law requires us to inform you of the following: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Please answer *all* questions, then sign and return the application to:

Western Washington AHEC, 1201 Monster Road SW, Suite 440 Renton WA 98057
Phone: 206-441-7137
Fax: 206-441-7158