

IMPORTANT: Please do not leave any questions incomplete. Unanswered questions or incomplete information including requested supporting documents will delay the underwriting of your application. Please print or type your answers. If additional space is required, please use the "Remarks" section at the end of the application.

APPLICATION CHECKLIST

- Copy of license
- Copy of DEA Registration Number
- Copy of Board Certification
- Current curriculum vitae
- If applicable, statement from your insurance carrier indicating whether or not your policy extends coverage to you as a Locum Tenens while working for another physician (see question 8)
- If applicable, your most recent professional liability declarations page and loss run report (see question 9)
Your insurance carrier will provide these upon request.

Please allow a minimum of three weeks for Underwriter review. If approved, applications are valid for one year.

SECTION I: APPLICANT INFORMATION

1. Name: _____ 2. DOB: _____
last first middle mo/day/yr

3. Social Security Number: _____ 4. Current Medical License Number: _____
state number

5. Are you licensed to practice in any other state(s)? Yes No

_____ license number

_____ license number

6. Home address: _____
street city state zip code

Phone number: _____ E-mail address: _____
area code number

7. Male Female

8. **IMPORTANT:** If you currently have coverage under a professional liability policy, please request from your carrier a letter or document indicating that your policy does or does not extend coverage to you as a Locum Tenens while working for another physician. Please include this statement when submitting your application.

9. Where have you practiced medicine in the past 5 years? Include military and public service organizations. Please provide a copy of your **declarations page and loss run** from your *most recent* professional liability insurance carrier. If you have not practiced medicine continuously, please explain/document those time periods in the "REMARKS" section. Use the "REMARKS" section to explain any time periods in which you worked *exclusively* as a locum tenens physician.

a. _____
facility name

_____ street address city state dates

_____ professional liability insurance carrier policy #

b. _____
facility name

street address _____ city _____ state _____ dates _____

professional liability insurance carrier _____ policy # _____

10. Medical School: _____
name of school

city _____ state _____ year graduated _____ degree _____

If you are a foreign medical school graduate, are you certified by the Education Council for Medical School Graduates?

Yes No If "Yes," have you passed the FLEX? Yes No

11. Residency: _____
name of school

city _____ state _____ to _____
dates attended

Was residency completed? Yes No

If "No," please explain: _____

12. Board Certification: _____
name of board _____ date certified _____ recertified _____

13. If you are not Board Certified, have you taken and failed board exams? Yes No

Are you Board eligible? Yes No Date eligibility expires: _____ / _____
month year

If not Board Certified and/or Board eligible, please explain in the "REMARKS" section.

14. Principal medical specialty: _____

15. If you hold any hospital privileges, please complete the following:

Hospital: _____ Category of privilege: _____
(active, consulting, courtesy, etc.)

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(active, consulting, courtesy, etc.)

SECTION II: LOCUM TENENS INFORMATION *

16. Name of physician you will be providing Locum Tenens coverage for: _____

Name of clinic or hospital to which the above physician belongs (if not a solo physician): _____

Please state the reason for the physician's absence: _____

17. Desired dates of coverage: _____ to _____

If days are not consecutive, please indicate actual coverage dates: _____

18. If the dates and the name of the physician you are filling in for are not yet scheduled, please explain here: _____

* Coverage cannot be issued until we know: physician(s) you are filling in for, date(s) of coverage, and reason(s) for physician's absence.

SECTION III: IF ANY ANSWER TO QUESTIONS 19 THROUGH 34 IS "YES," USE THE "REMARKS" SECTION TO PROVIDE DETAILS. PROVIDING ADEQUATE DETAIL AND DOCUMENTATION WILL ASSIST US IN EXPEDITING OUR UNDERWRITING REVIEW.

19. Has your license to practice medicine or dispense narcotics in any jurisdiction ever been limited, denied, revoked, suspended, or voluntarily surrendered or subjected to probationary conditions, or have proceedings towards any of those ends been instituted against you?

Medical License Yes No

DEA License Yes No

20. Have any complaints ever been filed against you with a governmental agency, medical or professional society, or other medical entity?

Yes No

21. 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 an intent to pursue such action?

Yes No

22. If "Yes," did the proceedings or review result in reprimand, censure, sanction, or modification of 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

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

Yes No

NOTE: A conviction record will not automatically bar or disqualify you from obtaining insurance.

24. Have you ever been charged or convicted of a felony?

Yes No

25. Have you ever been under punitive or disciplinary observation, preceptorship, or sponsorship in a hospital, or has any hospital notified you of its intent to pursue such action?

Yes No

26. Have your hospital privileges ever been restricted, suspended, revoked, non-renewed, or denied, or has any hospital notified you of its intent to pursue such action?

Yes No

27. Has the threat or avoidance of disciplinary action ever caused you to voluntarily relinquish a medical staff membership, clinical privilege, professional license, or narcotics registration?

Yes No

28. 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

29. Have you ever been diagnosed with, been treated for, or are currently being treated for alcoholism and/or chemical dependency?

Yes No

30. Have you ever incurred or become aware of having an illness or physical disability that impairs or could impair your ability to practice your medical profession (e.g., convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, hearing or vision impairment, Hepatitis B or C, HIV)?

Yes No

31. If "Yes," in the "REMARKS" section, state illness or disability with date(s), and provide the name of and a statement from your treating physician attesting to your fitness to practice your profession.

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

Yes No

33. If "Yes," give full details on the Claim Information Supplement, which is attached as part of this application, for ALL claims even if closed for no payment.

34. Have you ever been accused of sexual misconduct?

Yes No

35. Have you ever had contact of a sexual nature with a patient or former patient?

Yes No

36. Have you practiced without insurance at any time?

Yes No

CLAIM INFORMATION

(NOTE: please make copies of this form for additional claims)

No claims. A signature is required regardless of claims history.

1. Name of patient: _____ 2. DOB: _____ 3. Sex: _____

4. Allegation: _____

5. Date of incident: _____ 6. Date reported: _____

7. Insurance carrier: _____

Was a lawsuit filed? Yes No

8. Additional defendants: _____

9. Location of occurrence: _____

10. Disposition of claim: _____

11. Amount of settlement or judgment: _____

If claim is still open, reserve amount: _____

The following questions should be answered in adequate clinical detail to allow proper evaluation. Please attach copies of patient's charts and operative notes as appropriate. Attach additional sheets as required, in duplicate.

12. Condition and diagnosis at time of incident: _____

13. Date and description of treatment rendered: _____

14. Condition of patient subsequent to treatment: _____

I understand information submitted herein becomes part of my Professional Liability Insurance Application as submitted.

Applicant's Signature*

Date

** Signature line must be signed and dated even if you have no claims to report.*

APPLICANT'S REPRESENTATION (READ CAREFULLY)

I hereby represent that the information contained in this application and any supplemental submission is complete and true and that no material facts which are reasonably likely to influence the judgment of Physicians Insurance in considering this application have been omitted. I agree that this shall be the basis of the locum tenens coverage provided to me and that I will notify Physicians Insurance of any changes contained herein.

APPLICANT'S AUTHORIZATION AND RELEASE (READ CAREFULLY)

I acknowledge that as a condition precedent to acceptance of this application, an inquiry and investigation of my professional background, qualification 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 attending or treating physicians, 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 consultant 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.

Applicant's Signature

Date

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.

I understand that signature of this application does not bind the company to complete this insurance.

(A photocopy or facsimile of this Authorization shall be considered as effective and valid as the original.)

Your application will not be reviewed if the following supporting documents are not included.

Please remember to attach these documents with your application:

1. Copy of license
2. Copy of DEA Registration Number
3. Copy of Board Certification
4. Current Curriculum Vitae
5. If applicable, statement from your insurance carrier indicating whether or not your policy extends coverage to you as a Locum Tenens while working for another physician (see question 8)
6. If applicable, your most recent professional liability declarations page and loss run (see question 9)

Please return to: Seattle Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
1730 Minor Avenue, Suite 1800
Seattle, WA 98101
(206) 343-7300 (800) 962-1399

Eastern Regional Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
421 W. Riverside Avenue, Suite 1200
Spokane, WA 99201
(509) 456-5868 (800) 962-1398

