

Please answer all questions.

Practitioner Name _____ Policy Number _____

1. Are you board certified or board eligible the for American Board of Surgery? Yes No
If not, do you plan to become certified? Yes No When? _____
2. Are you a member of the American Society of Bariatric Surgery? Yes No
3. Which types of bariatric surgery procedures do you perform, and approximately how many surgeries per month do you perform of each?

<i>PROCEDURE</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>NUMBER OF PROCEDURES/MONTH</i>
Roux-en-Y Gastric Bypass	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Mini Gastric Bypass	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Vertical Banded Gastroplasty	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Silastic Ring Gastroplasty	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Biliopancreatic Diversion	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other—describe	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Which procedures are done laparoscopically? _____

***Please provide the consent form for each procedure.**

4. Please provide information regarding your training and certification for each type of surgery identified above that you perform. This should include the number of procedures you performed, the number of procedures you assisted during training, specific details on how many proctored procedures you performed and specifics on equipment/instruments used:

***Please provide copies of certification documents.**

Also provide documentation of your continuing education which relates to Bariatric Surgery.

5. How many bariatric surgeries did you perform in the past year? _____
6. How many bariatric surgeries did you perform in the past five years? _____
7. Describe any complications your patients encountered and the resolutions: _____

8. Do you advertise? Yes No ***If yes, please provide a copy of your ad.**
9. Do you have a website? Yes No ***If yes, please provide address.** _____
10. Do you provide seminars to the public? Yes No ***If yes, please include educational/written materials along with your most recent schedule or notice.**

Patient Criteria and selection

11. How many patients do you have or have you had under the age of 18? _____
Over the age of 59? _____

12. Please describe your patient screening process—this should include concurrent opinions of other specialists, such as cardiologists and psychiatrists:

***Please provide a copy.**

13. Describe your patient education and informed consent process:

***Please provide a copy of educational materials given.**

14. Do you have a Patient Care Team? Yes No
Is sensitivity training required of each team member? Yes No

15. The following is a list of possible positions of the Patient Care Team; please indicate name, designation (MD, RN, etc.) and describe the duties of each and the training each member has received. (This list may not be inclusive, so there is additional space for others):

Initial consultant (if other than you): _____

Patient program coordinator: _____

Psychological evaluator: _____

Dietitian/medical nutrition/psychologist: _____

Anesthesiologist: _____

What is the protocol for dealing with difficult airway intubation? *** Please include the checklist.**

Surgical Assist: _____

Other: _____

16. Describe the components of your follow-up procedures, including who implements them and who coordinates those procedures. Please include protocols used and ***provide a sample of these protocols:**

17. Please list the facilities used to perform the surgery:

No.	Facility & Location
1	
2	
3	
4	
5	
6	

- a. Do you have privileges to perform General or Gastrointestinal Surgery? Yes No
(if not at all locations, indicate which locations this applies to).
- b. Do you have privileges to perform Bariatric Surgery? Yes No
(if not at all locations, indicate which locations this applies to).
- c. Do your privileges extend to both open and closed procedures? Yes No

Hospital or Ambulatory Surgical Center Facility

In describing the facilities where you perform the surgery, please answer **yes** or **no** to the following:

<i>Equipment Description</i>	<i>Facility #1 Yes/No</i>	<i>Facility #2 Yes/No</i>	<i>Facility #3 Yes/No</i>	<i>Facility #4 Yes/No</i>	<i>Facility #5 Yes/No</i>	<i>Facility #6 Yes/No</i>
<i>Facility Name</i>						
Facility doors and elevator are enlarged to accommodate the oversized patient						
Oversized bed is provided						
Adjustable operating table is provided to accommodate the physician’s position during surgery and the patient size						
Patient room equipped with oversized toilet						
Guest and patient area are furnished with oversized seating						
Scopes used during surgery are sized sufficiently to allow for additional body mass						
Radiology/imaging equipment is sufficient to accommodate the oversized patient and obtain clear images in light of the patient body mass						
Staff is properly trained and intubation equipment is						

sufficient to accommodate the oversized patient						
Number of Bariatric surgical procedures performed during: Past year						
Past five years						

Who is providing the on call coverage and what are their qualifications in performing Bariatric surgery?

Describe the staff members involved in emergency and critical care for the obese patient and their qualifications and training. This should include any sensitivity training they received.

Describe available emergency equipment as it relates to the oversized patient.

REPRESENTATIONS

I hereby represent that the information contained in this application and any supplementary submission is complete and true and that no material facts which are reasonably likely to influence the judgment of Physicians Insurance have been omitted. I agree that this shall be the basis of the policy of insurance requested and that I will notify Physicians Insurance of any changes contained herein.

Date _____

Physician Signature _____

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 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

