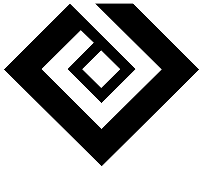

Return to:

PHYSICIANS AND OTHER HEALTHCARE PROFESSIONALS LIABILITY SUPPLEMENT

INSTRUCTIONS: **The Physicians and Other Healthcare Professionals Liability Supplement must be completed for each physician and healthcare professional.** Please complete the entire form. Please indicate "N/A" or "none" if a section does not apply, or is not relevant. Information provided will be used by underwriters to determine the acceptability of adding physicians and other designated healthcare professionals to Diamond State Group's Allied Health professional insurance coverage.

1. Your Name ________________________________Medical Facility Name__________________________________
2. Medical Specialty_______________________________________ Are you Board Certified? Yes___ No___
3. License Number/State ______________________________________
4. Is the coverage requested to be on a Primary or Excess basis? ______________
   (If Excess is requested, underlying limits of at least $1,000,000 per claim must be verified, and a copy of the Physician's or Healthcare Professional's primary medical malpractice insurance declaration page must be attached.)
5. What is your working relationship with the medical facility? Employee____ Contractor____ Volunteer____
6. Hours per week you work on behalf of the medical facility? ______ How many weeks per year? ______
7. List the responsibilities/duties you perform for the medical facility (please be specific).

   ____

   ____

   ____

8. Do you, or will you, perform any of the following medical procedures or services on behalf of the medical facility? If yes, how many per year?

	Times/yr.	None		Times/yr.	None
Physical Assessments	_______	_______	Medical Detox.	_______	_______
Methadone Treatment	_______	_______	HIV/AIDS Treatment	_______	_______
Infant/Child Medical Care	_______	_______	Labor / Delivery	_______	_______
Invasive Procedures	_______	_______	Wound Care	_______	_______

Lab Test Interpretation _______ _______ Prescribing Medications _______ _______

9. Do you provide any other medical procedures or service on behalf of the medical facility? Yes___ No___

   If yes, please describe below:

   ____

   ____

10. Do you obtain consent to treat patients? Yes___ No___

11. If the patient requires more specialized care, do you refer the patient to a specialist? Yes___ No___

    If yes, how do you determine the specialist that you refer the patient to?

    ____

    ____

    ____

13. Do you admit patients to the hospital? Yes___ No___ Discharge patients from the hospital? Yes___No___

    (If yes to any questions 14 – 18, please attach information and detailed description of the circumstances , claim or allegation.)

14. Have you ever had a malpractice claim or suit filed against you? Yes___ No___

15. Have you ever had your medical license revoked, suspended, restricted or on probation? Yes___No___

16. Have you ever been the subject of an investigation, disciplinary proceeding or reprimand? Yes___ No___

17. Have you ever been convicted of a crime or felony? Yes___ No___

18. Have you ever been treated for alcoholism or drug addiction? Yes___ No___

19. Provide information on **your** currently in-force malpractice insurance. (in none exists, please indicate "none")

    a. Insurance Company Name _________________________________Expiration date _________________

    b. Limits of Liability $_______________________________________Policy # ______________________

    c. Does you malpractice policy extend to cover you for your acts at the medical facility? Yes___ No___

I declare that the information contained in this application is true to the best of my knowledge and that no material facts have been suppressed or misstated. I understand that a material suppression of facts concerning the operations of the organization could void my coverage or result in a cancellation of coverage.

____
Physician's / Healthcare Professional's Signature

_______/_______/_______
Date

____
Signature of Applicant

_______/_______/_______
Date

____
Name and Title