PHYSICIANS AND PSYCHIATRISTS LIABILITY QUESTIONNAIRE

INSTRUCTIONS: **The Physicians and Psychiatrists Liability Questionnaire must be completed for each physician and psychiatrist.** Please complete the entire form. If a section does not apply or is not relevant, answer "N/A" or "none". Information provided by you will be used by underwriters in determining the acceptability of adding you to the Social Service Agency's professional insurance coverage.

FOR OFFICE USE ONLY – Please do not complete.	
☐ **United National Insurance Company**	☐ **Diamond State Insurance Company**
☐ **United National Specialty Insurance Company**	☐ **United National Casualty Insurance Company**

1. Your Name ____________________________________Agency 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, minimum underlying limits of $1,000,000 per claim must be verified and a copy of the Physicians primary declaration page must be attached)
5. What is your working relationship with the Clinic Center? Employee___ Contractor___ Volunteer___
6. Hours per week you work on behalf of the Agency? __________ How many weeks per year? __________
7. List the responsibilities/duties you perform for the Agency (please be specific).

   ____

   ____

   ____

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

	Times/yr.	None		Times/yr.	None
Entry Level Physicals	_______	_______	Medical Detox.	_______	_______
Methadone Treatment	_______	_______	HIV/AIDS Treatment	_______	_______
Infant/Child Medical Care	_______	_______	Prescribing Medications	_______	_______

9. Do you provide any other medical procedures or service on behalf of the agency? 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___

14. Have you ever had a malpractice claim or suit filed against you? Yes___ No___
    (If yes, please attach detailed claim information and a detailed description of the claim or allegation.)

15. Have you ever had your medical license revoked, suspended, restricted or placed 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. Do you have a private practice or provide services for any other agency or institution? Yes___No___

    If yes, please provide the details of your professional liability carrier(s) in the table below:

Insurance Company	**Policy Term**	**Retro Date, if Claims Made**	**Policy Limits**	**Premium**

20. Do any of the policies above extend to cover you for your acts at this Agency? 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 Signature Date

____ ________/________/________
Signature of Applicant Date

____
Name and Title