ADMIRAL INSURANCE COMPANY
6455 East Johns Crossing, Suite 240
Duluth, GA 30097
Phone: 770-476-1561 — Fax: 770-418-9597
Internet: http://www.admiralins.com

ANCILLARY EMPLOYEE APPLICATION PROFESSIONAL LIABILITY

PERSONAL INFORMATION

1. Name_____

2. Mailing Address _____

   Practice Address _____

3. Date of Birth _____Place of Birth_____

4. Phone No_____ Fax_____ Email Address_____

5. Insured is:

☐ Certified Nursing Assistant	☐ O.R. Technician (Hospital)	RN:	☐ Critical Care
☐ Dental Hygienist	☐ Optician		☐ ER
☐ Dietitian/Nutritionist	☐ Paramedic		☐ First Assist
☐ LPN, LVN, Aide, and First Year RN	☐ Perfusionist-Heart/Lung		☐ General Duty
☐ Med. Laboratory Technician	☐ Pharmacist		☐ OB
☐ Mental Health Counselor	☐ Physical Therapist		☐ Scrub
☐ Psychologist	☐ Psychotherapist		☐ Surgeon Assistant
☐ Respiratory Therapist	☐ CRNAs **		☐ Nurse Anesthetist**
☐ Nurse Practitioner**	☐ Physician Assistant (PAs)**		
☐ Other * _____			

*Describe General Duties_____
_____

For these occupations, the application supplement at the end of this application must be completed.

6. Is there a physician supervisor? ☐ Yes ☐ No If yes, please provide his/her name: _____

7. I request an Effective Date of 12:01a.m.on_____Retroactive Date_____

I request policy limits of: (select one)
☐ $250,000/$750,000 ☐ $500,000/$1,500,000 ☐ $1,000,000/$3,000,000
☐ Other _____

8. Type of Certification/License you currently hold. **(Attach copy to this application)**

__

List the states where you practice and license numbers, if applicable:

STATE	% OF PRACTICE IN STATE	LICENSE NUMBER	LICENSE STATUS ACTIVE

9. **Have you ever:**

a. Had your license or certification suspended, denied, revoked, restricted, or been the subject of any disciplinary actions in any state? ☐ YES ☐ NO

b. Had your insurance for medical malpractice refused, cancelled, suspended, nonrenewed, declined, or accepted on special terms? ☐ YES ☐ NO

c. Had any fee or professional relations complaints, registered against you with your association(s), hospital (s), state licensing authority, or certifying body? ☐ YES ☐ NO

d. Been denied staff or hospital privileges or had privileges suspended, terminated or revoked ? ☐ YES ☐ NO

e. Been treated or hospitalized for any mental or emotional disorders? ☐ YES ☐ NO

f. Incurred or become aware of having an illness or physical disability which impairs or could impair your ability to perform your duties? ☐ YES ☐ NO

g. Been charged with or convicted of a felony or misdemeanor other than minor traffic violations? ☐ YES ☐ NO

h. Been treated or hospitalized for use of any of the following:

i. alcohol ☐ YES ☐ NO

ii. narcotics ☐ YES ☐ NO

iii. central nervous system stimulants or depressants ☐ YES ☐ NO

MEDICAL EDUCATION

10. Institution _____State_____ Degree/Certificate_____

Dates from_____ to_____ Date Graduated_____

Institution _____State_____ Degree/Certificate _____

Dates from _____ to_____ Date Graduated _____

11. Describe any continuing medical education courses that you completed within the past two years._____

_____

_____

WORK EXPERIENCE (FOR THE LAST 7 YEARS)
*PLEASE ATTACH A CV

12. a. Employer Address Dates Employed

_____
_____
_____
_____
_____
_____
_____

b. Do you treat patients at a nursing home, assisted living facility, jail, or correctional facility? ☐YES ☐NO
If yes, please explain: _____
Percentage of Practice? _____

PRIOR PROFESSIONAL LIABILITY INSURANCE

13.

Name of Insurance Company	Insurer Policy Number	Policy Period	Claims Made or Occurrence	Retroactive Date

(Attach copy of current coverage summary sheet)

CLAIMS INFORMATION

14. Have you been involved in a malpractice claim or suit, including any expression of intent? (i.e. closed records requests, incident reports and notices of intent, even if suit was never filed) or you are presently involved in malpractice litigation? ☐ YES ☐ NO

If yes, submit a separate form for each case

15. Do you know or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that any of the following circumstances might reasonably lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit:

a. That have not been reported to your current OR prior professional liability carrier? ☐ YES ☐ NO
If yes, please explain: _____
b. A request for records from a patient and /or attorney related to an adverse outcome? ☐ YES ☐ NO
c. A letter or communication from a patient, patient's representative, friend, relative or attorney regarding your medical treatment of a patient? ☐ YES ☐ NO
d. Intra-operative complications or other complications resulting in death, paralysis or other significant disabilities? ☐ YES ☐ NO
e. Have any unexpected or potentially problematic results or incidents occurred in the past five years in the following categories?
i. Cardiac arrest ☐ YES ☐ NO
ii. Postoperative coma ☐ YES ☐ NO
iii. Postoperative neurological deficits ☐ YES ☐ NO
iv. Unexpected death within 48 hrs. postoperatively ☐ YES ☐ NO

16. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that a patient, or patient's representative, friend or relative was dissatisfied with the outcome of a procedure, treatment or diagnosis? ☐ YES ☐ NO

17. Has any other party (e.g. current or prior employer, physician etc,) been the subject of a claim due to your actions? ☐ YES ☐ NO

(Complete supplementary claims information form on each claim or suit)

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statement and representations made in this application and this application will be made a part of the policy. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

Date_____ Signature of Applicant_____

This application form duly completed together with any supplementary information must be signed in ink by the applicant. A signature on the form does not bind the applicant or the Company to complete the insurance.

FRAUD STATEMENT

Section 817.234(1)(b), Florida Statutes(if applicable)

The statue requires the statement to contain in substance the following language: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

PLEASE ATTACH THE FOLLOWING

a) Copy of your resume or CV.
b) Copy of your medical license or copy of certificate issued by the state.

APPLICATION SUPPLEMENT

Applies to Nurse Anesthetists, Nurse Practitioners, CRNAs, and PAs

1. Is your practice in? ☐ Office ☐ Hospital ☐ Other_____
   Describe role, activities and functions to be performed by the applicant in these settings:

_____

_____

_____

_____

_____

_____

_____

2. Describe in detail the acts, tasks and functions that the applicant will be allowed to perform under indirect supervision (i.e. away from your presence), and the safeguards (standing orders, backup arrangements, access via telephone, etc) which you have established for the protection of the patient.

_____

_____

_____

_____