Medical Professional Liability
Physician Renewal Application

CERTITUDE

ProAssurance Indemnity Company, Inc. • PO Box 150 • Okemos, MI 48805-0150 • 800.282.6242 • Fax 608.828.1100

Date:_____ Policy #:_____ Expiration Date:_____

Agent/Agency Name:_____ Phone:_____

Important: Please review, complete, and return this renewal application with a copy of your updated curriculum vitae and a copy of your current business letterhead. Please make any necessary changes to the pre-filled information below. Your prompt, accurate reply assists your policy's renewal. Thank you.

1. Personal Information

Name:_____ Degree:_____

Email Address:_____

Home Address:_____

City:_____ State:_____ ZIP:_____ Home Phone:_____

Practice Specialty:_____

Medical License Number(s):	State	License Number	Expiration Date	% of Practice

List all State Medical Associations you currently belong to: _____

2. Practice Location

Principal Office Street Address:_____

City:_____ County:_____ State:_____ ZIP:_____

Office Phone:_____ Office Fax:_____ Website:_____

Mailing Address:_____

Billing Address:_____

Contact Name:_____ Title:_____

Contact Email Address:_____

3. Practice Information

A. How many patients do you see on average per week? _____

B. How many hours do you practice per week? _____

(Practice hours include hospital rounds, charting, consultation with other physicians, patient visits/consultations, paramedical supervision, and on-call hours involving patient contact—whether direct or by telephone.)

C. Please give us the name of any newly formed or dissolved solo or professional group practice entity (e.g., P.A., P.C., L.L.C., L.L.P., Inc., etc.) or DBAs related to your practice:_____

_____

i. Do you desire coverage for this new entity? Yes ☐ No ☐

D. Do you serve as a Medical Director? Yes ☐ No ☐

If yes, please list the name of the facility(ies) and provide proof of coverage if insurance is provided by the facility for your duties as medical director:_____

E. Are you a professional sports team physician? Yes ☐ No ☐

If yes, provide the name of the team:_____

F. Do you perform medical or surgical procedures at an office-based surgical suite? Yes ☐ No ☐

If yes, provide entity and procedures in the space provided at the end of application.

G. Do you provide medical professional services (including opinions or advice) via the internet or any telemedicine program? Yes ☐ No ☐
If yes, what percentage of your practice does this constitute? _____%
i. Do you provide these services to patients in states outside your primary practice location? Yes ☐ No ☐
If yes, please provide a list of those states:_____

H. Do you provide services to any nursing home or correctional facility? Yes ☐ No ☐
If yes, provide name of facility(ies) and the percentage of your practice these services constitute? _____

I. Do you currently staff or do you anticipate staffing an emergency department? Yes ☐ No ☐
If yes, is the emergency department work required to maintain hospital staff privileges? Yes ☐ No ☐
i. How many hours per month do you practice in the emergency department?_____

J. Do you have a collaborative agreement with any paramedicals*? Yes ☐ No ☐
i. Are any of these persons involved in patient care/contact at facilities where you are not physically present? These include, but are not limited to, nursing homes, correctional facilities, extended care facilities, and satellite offices. Yes ☐ No ☐
ii. Are any of these persons not in your employ? Yes ☐ No ☐

Note: This question applies only to physicians who are the only physician named on the policy.

K. Do you currently employ paramedicals other than those listed below? Yes ☐ No ☐
Please mark any changes below, including any additional paramedicals:

Employee Name	**Specialty**	**Begin or Termination Date** (for additions or deletions)
[prefill w/parameds on policy]		

**Paramedicals include a person practicing as a psychologist, nurse midwife, nurse anesthetist, nurse practitioner, physician assistant, surgical assistant, perfusionist, optometrist, cytotechnologist, emergency medical technician, anesthesiologist assistant, or any person licensed, certified, or otherwise authorized to deliver advanced level health care in the absence of direct supervision by a licensed physician.*

4. Certification

A. Are you board certified? Yes ☐ No ☐
i. If yes, please indicate which board and specialty/subspecialty:
☐ American Board of:_____
☐ American Osteopathic Board of:_____
ii. If not boarded, when do you plan to take your Boards?_____
iii. Are you required to recertify? Yes ☐ No ☐
If yes, please provide date of recertification:_____
iv. Have you failed a Board certification or recertification examination within the last five years? Yes ☐ No ☐
If yes, how many times?_____

5. Procedures

A. Please review each section and check the procedures that apply to your practice. This information is used for rating purposes; the order in which the procedures are presented below does not represent rating classifications.

Anesthesia, Physical Medicine, Rehabilitation/Pain Management Procedures

☐ Anesthesia (Check type and where administered)

	Hospital	Surgical Suite	Office
☐ Caudal	☐	☐	☐
☐ Moderate (Conscious) Sedation	☐	☐	☐
☐ General	☐	☐	☐
☐ Spinal	☐	☐	☐

☐ Lumbar Puncture

☐ Pain Management
- ☐ Medication Only
- ☐ Spinal Cord Stimulators
- ☐ Facet Blocks
- ☐ Selective Nerve Root Blocks
- ☐ Rhizotomy
- ☐ Spinal Injections
- ☐ Dorsal Root Gangliotomies
- ☐ Thoracic Sympathectomies
- ☐ Implantation/Removal of Drug Infused Pumps
- ☐ Sphenopalatine Lesioning
- ☐ Trigeminal Lesioning
- ☐ Cordotomies
- ☐ Other:_____

☐ Trigger Point Injections

Procedures Continued

Radiology-Related Procedures

- ☐ Fluoroscopy
- ☐ Mammography
- ☐ Myelography
- ☐ Radiology – Interventional
- ☐ Radiation/X-ray Therapy
- ☐ Radiopaque Dye

Cosmetic/Dermatological Procedures

- ☐ Blepharoplasty
- ☐ Botox Injections
- ☐ Chemical Peels
- ☐ Chemabrasion
- ☐ Collagen Injections
- ☐ Cryosurgery (superficial only)
- ☐ Dermabrasion
- ☐ Dermatopathology (diagnostic)
- ☐ Fat Transfer
- ☐ Hair Transplants
- ☐ Laser Hair Removal
- ☐ Laser Skin Resurfacing
- ☐ Laser Vein
- ☐ Lipodissolve/Mesotherapy
- ☐ Liposuction
- ☐ Microdermabrasion
- ☐ Sclerotherapy
- ☐ Silicone Injections
- ☐ Other:_____

Surgical (Invasive) Procedures

- ☐ Angioplasty
- ☐ Assist in surgery
  - ☐ On Own Patients
  - ☐ On Patients of Others
- ☐ Bariatric Surgery
- ☐ Bronchoscopy
- ☐ Cardiac Surgery
- ☐ Cholecystectomy
- ☐ Circumcision (other than newborns)
- ☐ Colonoscopy
- ☐ Colposcopy
- ☐ Cryosurgery (other than external lesions)
- ☐ D&C
- ☐ Endoscopic Laser Therapy
- ☐ Endoscopy other than Proctoscopy, Sigmoidoscopy, Colposcopy, and Cystoscopy
- ☐ ERCP/EGD/ERC
- ☐ Fracture Reductions
  - ☐ Open
  - ☐ Closed
- ☐ Hand Surgery
- ☐ Head and Neck Surgery
- ☐ Hemorrhoidectomy
- ☐ Hernia Repair
- ☐ Hyperbaric Medicine/Wound Care
- ☐ Hysterectomy
- ☐ Hysteroscopy
- ☐ Left Heart Catheterization
- ☐ Obstetrics/Gynecology – Major Surgery
  - ☐ Vaginal Deliveries Number Per Year:_____
  - ☐ C-Sections Number Per Year:_____
  - ☐ VBAC Number Per Year:_____
- ☐ Ophthalmology Surgery
- ☐ Orthopedic – Major Surgery
  - ☐ Spines
  - ☐ No Spines
- ☐ Otorhinolaryngology – Major Surgery
  - ☐ Including Elective Cosmetic Procedures
- ☐ Penile Implants
- ☐ Permanent Pacemaker
- ☐ Plastic – Major Surgery
- ☐ Robotic Surgery
- ☐ Roux-en-y (non-bariatric)
- ☐ Thoracic Surgery:_____% of Practice
- ☐ Tonsillectomy/Adenoidectomy
- ☐ Tubal Ligation
- ☐ Transgender Surgery
- ☐ Trauma Surgery
- ☐ Vascular Surgery:_____% of Practice
- ☐ Vasectomy

Other Procedures

- ☐ Abortions
- ☐ Angiography/Arteriography
- ☐ Breast Biopsy
- ☐ Chelation Therapy (for other than heavy metal poisoning)
- ☐ Echocardiography
- ☐ ECT (Shock Therapy)
- ☐ Fertility Treatment
- ☐ Hormonal Gender Conversion (other than genetic)
- ☐ Independent Medical Exams:_____% of Practice
- ☐ Lithotripsy
- ☐ Neonatology
- ☐ Percutaneous Vertebroplasty
- ☐ Prenatal Care
- ☐ Prolotherapy
- ☐ Weight Control:_____% of Practice

Medications Prescribed (please list):_____

_____

_____

_____

i. If none of the above procedures apply to your practice, please initial here: _____

ii. Do you perform procedures that are outside the customary scope of practice within your specialty? ☐Yes ☐No

If yes, please list procedures: _____

_____

iii. Do you perform any diagnostic or therapeutic procedures which have been introduced to the medical profession within the past two (2) years? ☐Yes ☐No

If yes, please provide the name of the procedures in the space provided at the end of this application.

I have noted below and agree to notify the Company going forward of any the following events within thirty (30) days of its occurrence: (Please note any circumstances below under Additional Comments.)

A. A change in my specialty or medical procedures performed;

B. A change in my practice location, my provision of services to out-of-state patients, or telemedicine services;

C. Complaint, grievance, investigation, restriction, suspension, or surrender of any state medical license, DEA license, or hospital privileges;

D. Investigation of my Medicare/Medicaid billing procedures;

E. Any physical or mental condition or illness, including treatment for alcohol or substance abuse or any accusation of sexual misconduct or inappropriate contact not previously disclosed to the Company in writing;

F. Conviction, plea, or agreement related to any charges of a misdemeanor or felony (including DUI, DWI, OUI) other than minor traffic offenses;

G. A claim or suit for alleged malpractice has been made against me and reported to **another insurance carrier or hospital self-insured trust**, or if any claim or suit resulted in payment by me or on my behalf, since I became an insured of a ProAssurance company.

I acknowledge that information concerning any of the events described above is material to the provision of insurance under the policy on the basis and for the premium stated in the Coverage Summary of the policy.

Failure to notify the Company of such changes could require retroactive upward premium adjustment and, in the event of a claim, could lead to denial of liability.

Fraud Warning – I acknowledge the applicable fraud warning for my state as shown on the Fraud Warning Notices Page.

I hereby declare and represent that the foregoing statements and particulars are, to the best of my knowledge and recollection, complete, and that I have not willfully concealed, omitted, or misrepresented any material fact or circumstance concerning this insurance or the subject thereof:

Date: _____ **Signature of Insured Physician:** _____

Additional Comments

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please attach additional sheets as necessary.

Current Certificate of Insurance Holders:
(Please cross out any certificate holders that are no longer applicable, and use the additional lines to add other certificate holders to whom we should mail a Certificate.)

Include Name, Address, and Phone

_____

_____

_____