

Physician & Surgeon Practice Hours Supplemental Application



Completion of this supplemental application is required based on answers provided on your application for medical professional liability coverage. Please be advised all information disclosed on this form is subject to the anti-fraud statement contained on the initial application.

Insured Physician's Name: _____

Specialty: _____

Policyholder Name: _____ Policy Number: _____

- 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).
- Is your practice less than full-time because of any of the following? (Check all that apply)
 - Semi-retirement
 - Disability
 - Majority of practice is conducted in a teaching role (which is insured elsewhere)
 - Majority of practice is insured through another entity (such as an employer)
 - Pregnancy or dependent care
 - Maintenance of another practice in a bordering state (which is insured elsewhere)
 - Other: _____

3. How many hours is the practice for which you provide services open per week? _____

4. Indicate total number of hours per week devoted to the following activities:

Practice Activities	Hours Per Week
Your actual patient care (including hospital rounds and supervision of paramedicals):	_____
Your time supervising paramedicals:	_____
Your time on-call:	_____
Your time spent at a lab or other medical/dental facility:	_____
Your administrative tasks and duties related to your practice (including telephone contact with patients and charting):	_____
Your time consulting with other health care providers:	_____
Your surgeries and assisting in surgeries:	_____
Your house calls and/or nursing home visits:	_____
Your other patient care-related activities:	_____
Other: _____	_____

5. List all other practice locations for which **coverage is not needed**.
If additional space is needed, please attach a separate sheet.

Name & Address	Hours per Week	Specialty Practiced	Insurance Carrier
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature: _____ Date: _____