

Medical Professional Liability Physician Renewal Application



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 paramedics*? Yes No
 i. Are any of these persons involved in patient care/contact at facilities where you are not physically present? Yes No
 These include, but are not limited to, nursing homes, correctional facilities, extended care facilities, and satellite offices.
 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 paramedics other than those listed below? Yes No

Please mark any changes below, including any additional paramedics:

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

**Paramedics 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)
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> Caudal | <u>Hospital</u> | <u>Surgical Suite</u> | <u>Office</u> |
| <input type="checkbox"/> Moderate (Conscious) Sedation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> General | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Spinal | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Lumbar Puncture
- Pain Management
- | | |
|--|---|
| <input type="checkbox"/> Medication Only | <input type="checkbox"/> Thoracic Sympathectomies |
| <input type="checkbox"/> Spinal Cord Stimulators | <input type="checkbox"/> Implantation/Removal of Drug Infused Pumps |
| <input type="checkbox"/> Facet Blocks | <input type="checkbox"/> Sphenopalatine Lesioning |
| <input type="checkbox"/> Selective Nerve Root Blocks | <input type="checkbox"/> Trigeminal Lesioning |
| <input type="checkbox"/> Rhizotomy | <input type="checkbox"/> Cordotomies |
| <input type="checkbox"/> Spinal Injections | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dorsal Root Gangliotomies | |
- 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.

Purchasing Group Intent to Join

The undersigned insured hereby consents to join the Ascension Health Risk Purchasing Group Inc., a purchasing group formed under the provision of the Liability Risk Retention Act of 1986. One of the purposes of this group is to purchase insurance on a group basis. ProAssurance Indemnity Company, Inc., with its home office located in Birmingham, Alabama, underwrites insurance policies issued for this group and may not be subject to all the rules and regulations of your state.

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
