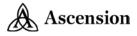


Application for Limited Professional Liability Coverage Insured Paramedical Employee

⊕CERTITUDE

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

Re	Requested Effective Date: / /						
Na	me (Last, First, MI):						
SSN:			5	Sex: Male 🗌 Female 🗌			
Но	me Address:	City:	State:	ZIP:			
Cu	rrent Employer:		Telephone Number:				
Bu	siness Address:	City:	State:	ZIP:			
1.	Profession:						
	 Physician Assistant Surgical Assistant Psychologist Certified Nurse Midwife 	 Perfusionist Optometrist Cytotechnologist 	 Certified Nurse Practitioner Certified Registered Nurse Anest Emergency Medical Technician 	thetist			
2.	Is your employer insured by a ProAssurance	e Company?		Yes 🗌 No 🗌			
3.	 Have you ever: A. Been convicted of a criminal offense? B. Been treated for (or recommended for C. Undergone psychiatric treatment? D. Had a complaint filed against you with E. Had any professional license/permit or or placed under probation? If the answer to 3.A., 3.B., 3.C., 3.D., or Do you moonlight (work outside control of 	any hospital or regulatory board narcotics license investigated, s 3.E. is yes, please provide cor	15	Yes □ No □ Yes □ No □			
5.	If yes, where did you receive your training?		Yes 🗌 No 🗌				
7.	Have any judgments ever been rendered aga behalf from an incident alleging professiona If yes, please give details on a separate sheet	l errors or omissions?	tlements in excess of \$500 been made on you	ur Yes 🗌 No 🗌			



8.	 Has any action been filed against you or have you been notified that any action, regardless of dollar amount, will be filed against you alleging professional errors or omissions? If yes, please give details on a separate sheet. If available, please enclose copy of complaint. 					
9.	Has an insurance company, including Lloyd surcharged your premium, or issued coverag			Yes 🗌 No 🗌		
10.	Will you be scheduled to work at a separate	location from your supervising phy	sician?	Yes 🗌 No 🗌		
	If yes, please give details on a separate sheet					
11.	Does your practice comply in every way with with licensing and monitoring individuals in		rth by the agency in your state charged	Yes 🗌 No 🗌		
12.	2. Do you elicit, record, and evaluate a health, psychosocial, and developmental history of the patient?			Yes 🗌 No 🗌		
13.	13. Do you order or perform diagnostic tests?					
14.	14. Do you discriminate between normal and abnormal findings on the history, physical, examination diagnostic tests, initiate referrals and consultations when needed?					
15.	Do you regulate or adjust medications and t	reatment as prescribed by or author	ized by a licensed physician?	Yes 🗌 No 🗌		
16.	Do you perform a physical examination?					
	If yes, briefly describe techniques and instru	ments used:				
17.	Do you conduct informed consent discussion	ons?		Yes 🗌 No 🗌		
18.	 Describe any other procedures, treatments, or duties you perform: 					
19.	Describe your procedure for notifying your	supervising physician of situations l	beyond the scope of your training or practice:			
20.	Please list all states in which you are licensed along with each license number and renewal date:					
	State	License Number	Renewal Date			
21.	Please include copies of the following:					
	A. Current Curriculum Vitae					
	B. Copy of your approved notification of supervision form					
	C. Copy of current professional liability insurance declarations pageD. Claims history					
	E. Copies of your practice protocols					
	Setter and and hundred brokerse					

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

Consent to Conditions of Consideration of the Application for Insurance

I accept the following conditions during the processing and consideration of my application-regardless of whether or not I am granted insurance-and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release ProAssurance, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents, or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

Applicant's Signature:

Important: Incomplete or incorrect information could require retroactive upward premium adjustment and, in the event of a claim, could lead to a denial of coverage. The following is an Authorization to Release Information which requires your signature. Please read it carefully.

Authorization to Release Information

I, the undersigned hereby authorize my present and prior professional liability carriers, any and all attorneys who have represented me in connection with any claim of professional liability, and any other individuals, associations or entities having information regarding me, to release to ProAssurance upon its request, any information which in the judgment of any such person noted above, may have bearing upon my acceptability to ProAssurance as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

I hereby release and agree to hold harmless all persons or organizations, their agents, servants, and employees, ProAssurance, its directors, officers, employees and agents from any liability arising from releasing the above information, notwithstanding the fact that there may be errors, omissions or mistakes contained in such released information.

I further agree that ProAssurance and all persons and organizations described above may rely upon a photo copy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed):

Applicant's Signature: _____

Note: ProAssurance's Privacy Policy can be found on ProAssurance.com.

Fo	or Agent's Use Only (if applicable)	
Agent's Name and License Number	Agency Name	
Signature	Agency Address	
Date	Phone	

Insured Physician's Authorization

I hereby request the above applicant be added to my Policy as an Insured Paramedical Employee. I understand that such coverage is subject to underwriting approval.

Requested Effective Date:

Signature of Insured Physician/Supervising Physician

Shared Limits Coverage

Separate	Limits	Coverage	
ooparate		Soverage	

Note: Separate Limits Coverage is not available for Cytotechnologists.

Date

Date:

Date: