Physician & Surgeon Practice Hours Supplemental Application

CERTITUDE

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: _____

1. 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).

2. 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: _____