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APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE CLAIMS MADE POLICY

IMPORTANT: You are applying for CLAIMS MADE COVERAGE. For your own protection, report to your CURRENT insurer BEFORE YOUR CURRENT POLICY EXPIRES ANY:
Incident which might lead to a claim;
Request for medical records;
Unfavorable result in treatment;
Knowledge of a patient or family member who might consider bringing a claim against you.

THIS APPLICATION WILL BE ATTACHED TO AND FORM A PART OF ANY POLICY THAT MAY BE ISSUED

- Applicant must personally complete this application.
- Please type or print legibly in black ink.
- You **MUST** attach a curriculum vitae (CV) to this Application or complete Form G and your CV will be incorporated into this application and any policy that may be issued.
- You **MUST** attach the declarations page of your current policy.
- You **MUST** report all circumstances that might reasonably be expected to result in a claim or suit, even if you believe that the claim or suit would be without merit.
- If the applicant or claimant knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- Every** question must be answered. If a question does not apply to you, mark it "N/A" (not applicable).
- If space is insufficient for a complete reply, please attach a separate sheet.
- Incomplete answers and/or missing attachments may delay the processing of your application.
- This is an Application only. Completion of this Application or its receipt by MPM or an agent or broker does not bind MPM to issue a policy to you. Before coverage can be bound or a policy issued, this Application must be approved by MPM's underwriting department and the initial payment must be received by MPM or its agent.

I. GENERAL INFORMATION

1.	Name of Insured	
	Primary Office Address	(First) (Middle) (Last) (M.D./D.O./other)
	Mailing Address	(Number) (Street) (City) (State) (Zip) (County)
	Residential Address	(Number) (Street) (City) (State) (Zip) (County)
	Billing Address	(Number) (Street) (City) (State) (Zip) (County)
	(if different from mailing)	(Number) (Street) (City) (State) (Zip) (County)
	Telephone Numbers	() _____ - _____ () _____ - _____ () _____ - _____ (Office) (Office Fax) Residential
	Email	_____ @ _____
	Social Security #	_____ - _____ - _____
	Date of Birth	_____/_____/_____
	<p>Please identify a contact person the Company may contact relating to the information contained in this application as well as future claims or incidents.</p> <p>Contact Name: _____</p> <p>Title: _____</p> <p>Telephone Number: _____</p>	
	<p>Please provide the name of all professional and/or medical societies of which you are a member.</p> <p>_____</p>	

II. POLICY OPTIONS

2.	Desired Effective Date	_____/_____/_____						
3.	Limit of Liability (circle one) per occurrence/annual aggregate	<table> <tr> <td>\$100,000/\$300,000</td> <td>\$200,000/\$600,000</td> <td>\$500,000/\$1,000,000</td> </tr> <tr> <td>\$500,000/\$1,500,000</td> <td>\$1,000,000/\$1,000,000</td> <td>\$1,000,000/\$3,000,000</td> </tr> </table>	\$100,000/\$300,000	\$200,000/\$600,000	\$500,000/\$1,000,000	\$500,000/\$1,500,000	\$1,000,000/\$1,000,000	\$1,000,000/\$3,000,000
\$100,000/\$300,000	\$200,000/\$600,000	\$500,000/\$1,000,000						
\$500,000/\$1,500,000	\$1,000,000/\$1,000,000	\$1,000,000/\$3,000,000						
4.	Do you want prior acts coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No <p>If your current policy is or any previous policies are claims made and you cancel the policy without purchasing an extended reporting endorsement (tail coverage), there will be no coverage for any claim from any act or omission that took place during that period of claims made coverage. However, you may apply for a policy with a retroactive date back to the first day of your previous claims made policy.</p> <p>Prior Acts Coverage is not granted automatically. Therefore, it is important that you keep your present coverage current and in force so that you do not forfeit your right to purchase tail coverage from your present carrier. Even if prior acts coverage is written, it will not cover any claims, conduct, circumstances, occurrences, accidents, or medical incidents likely to give rise to a claim which are known to you or which should have been known to you on the date of this application.</p>						

5.	Prior Acts Limit of Liability (circle one)	\$100,000/\$300,000	\$200,000/\$600,000	\$500,000/\$1,000,000
		\$500,000/\$1,500,000	\$1,000,000/\$1,000,000	\$1,000,000/\$3,000,000
6.	Deductible requested	<input type="checkbox"/> None <input type="checkbox"/> \$20,000 Other _____	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$30,000	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$50,000
7.	Retroactive Date Requested for you	_____ / _____ / _____		
7a.	Retroactive Date Requested for entity (see Question 19)	Name of Entity: _____ Retroactive Date: _____ Name of Entity: _____ Retroactive Date: _____ Name of Entity: _____ Retroactive Date: _____		

III. EDUCATIONAL BACKGROUND

PLEASE ATTACH A COMPLETE COPY OF CURRENT C.V. (with all educational information including but not limited to medical school (s), internships, residency, type of residency, military training and experience. If you do not have a current C.V. you may complete FORM G)

8. State(s) where currently licensed:
- a. _____ # _____ % of Practice _____
- b. _____ # _____ % of Practice _____
- c. _____ # _____ % of Practice _____
9. DEA License# _____

PRACTICE HISTORY

10. Present _____ from ___/___/___ to ___/___/___
(type of practice) (City and State)
- Prior _____ from ___/___/___ to ___/___/___
(type of practice) (City and State)
- Prior _____ from ___/___/___ to ___/___/___
(type of practice) (City and State)

11. Please explain any breaks of more than 3 months in your training or practice:

12. **Changes in Practice:** Have your practice procedures, specialty or location changed in the last ten (10) years? Yes No If YES, please explain _____

13. How many hours of continuing medical education do you attend annually: _____

14. Foreign medical school graduates:
Are you certified by Education Commission for Foreign Med School Graduates (ECFMG)? Yes No
Do you hold the foreign equivalent of board certificates? Yes No
If YES, please explain _____

BOARD CERTIFICATION (Must be recognized by the American Board of Medical Specialist or the American Osteopathic Association)

15a. Specialty _____ % of Practice _____ Board certified? Yes No

15b. Subspecialty _____ % of Practice _____ Board certified? Yes No

16. If not board certified, are you board eligible? Yes No

If YES, expected date you plan to become board certified ____/____/____

If NO, please explain _____

IV. INFORMATION ABOUT YOUR PRACTICE

17. **Type of practice:**

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> Solo | <input type="checkbox"/> Partnership | <input type="checkbox"/> Employee |
| <input type="checkbox"/> Solo and Professional Assn. | <input type="checkbox"/> Professional Assn. | <input type="checkbox"/> Contractor |
| <input type="checkbox"/> Solo and Professional Corp | <input type="checkbox"/> Professional Corp | <input type="checkbox"/> Resident |
| <input type="checkbox"/> Correctional Institution | <input type="checkbox"/> Nursing Homes | |

Indicate if you:

- Share professional employees Share calls
- _____ # of physicians, outside your group, you share calls with?
- Common billings Other (describe) _____
- Share profits Other (describe) _____

18a. Name of every Corporation, Association, Partnership or Employer you have been associated with or employed by after the date you have requested for your Retroactive Date:

- _____ Is this a Missouri entity? Yes No
- _____ Is this a Missouri entity? Yes No
- _____ Is this a Missouri entity? Yes No
- _____ Is this a Missouri entity? Yes No

18b. Which entity(ies) listed in Question 18 are you currently employed by or associated with?

19. For which of the entities described in Question 18 do you wish to obtain insurance coverage for your acts?

Additional insured (no separate limit: no additional premium) Yes No

Separate limit of coverage (additional premium required) Yes No

20a. Please list all medical doctors, doctors of osteopathy, physicians, surgeons, physicians' assistants, certified registered nurse anesthetists, certified nurse midwives, midwives and advanced practice nurses employed by or associated with you or your group:

Name	Dates of Employment	Present Insurer	Policy Number	Expires
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

21. How many of the following non-physician individuals are employed by or associated with you or your group?

Acupuncture Technicians Nurse Anesthetists (CRNA)* Physician Assistants (PA)*
 Clerks (non-medical) Nurse Midwives (CNM)* Psychologists
 Medical Assistants Nurse Practitioners (NP)* Other _____
 Nurses (not otherwise listed) Optometrists * see question #23 below

22. Total Number of Employees/agents: _____

23. List below the name of each individual currently employed by or associated with you or your group (if not previously listed in Question 20):

Name	Title
_____	_____
_____	_____
_____	_____

24a. Are any of the individuals listed in questions #20 or #23 independent contractors?

Yes No

If YES, do the independent contractors have their own individual coverage?

Yes No

If YES, please provide a certificate of insurance. If NO, described the coverage arrangements:

24b. Since the retroactive date requested (see question #7), have you ever employed or provided or do you currently employ or provide supervision to any other person (including advanced practice nurses and physicians assistants) licensed, certified or otherwise authorized to provide advanced health care services in the absence of direct supervision by a licensed physician?

Yes No

If YES, please provide the following information for each such person:

Name	Specialty	Employee	Supervise Only
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

24c. Since the retroactive date requested (see question #7), have you ever been or are you now subject to a collaborative practice agreement or arrangement with any other person (including advanced practice nurses and/or physicians assistants) licensed, certified or otherwise authorized to provide advanced health care services in the absence of direct supervision by a licensed physician?

Yes No

If YES, please provide the following information for each such person:

Name	Specialty	Employee	Supervise Only
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

25. Since the retroactive date requested (see question #7), have you ever engaged or do you currently engage in any "moonlighting" activity?

Yes No

26. Since the retroactive date requested (see question #7), have you ever worked or do you currently work in an "urgent care" or similar setting?

Yes No

27. Since the retroactive date requested (see question #7), have you ever worked or do you currently work in an industrial clinic?
 Yes No
28. Since the retroactive date requested (see question #7), have you ever worked or do you currently work in a free-standing emergency or urgent care center?
 Yes No
29. Since the retroactive date requested (see question #7), have you ever worked or do you currently work in a free-standing "birthing clinic" or similar facility?
 Yes No
30. Since the retroactive date requested (see question #7), have you ever functioned or do you currently function as a hospitalist?
 Yes No

If YES, provide the name of the hospital and describe the duties performed:

If you answered YES to any of the above questions #25 through #30, please explain (include in explanation the name of entity, location, duties, number of hours worked and whether separate malpractice was provided for such activity):

31. Since the retroactive date requested (see question #7), have you ever served or do you currently serve on a trauma team? Yes No

Please explain any YES answers: _____

32. Volume of practice (weekly average):

Number of patients seen by you in office: _____ per week

Number of patients seen by you in hospital: _____ per week

Number of patients seen only by paramedical personnel employed by you: _____ per week

Average weekly total _____

Please indicate average number of hours per week:

Office practice _____ hours Emergency room _____ hours

Hospital practice _____ hours On-Call _____ hours

If Part-Time: When did you start practicing part-time: _____/_____/_____

Are you involved in another part-time practice for which you have coverage? Yes No

If YES, please explain _____

If you are applying for Part-Time Coverage, please complete Form H – Request for Part-Time Coverage.

33. List additional practice locations including all offices, nursing homes, urgent care clinics and other non-hospital locations. Please identify additional location (i.e., additional private practice office, nursing home, clinic, etc.)

 Type of Practice

 Number Street City State Zip County % of Practice time at this location

 Telephone #

 Fax #

 E-Mail Address

34. Since the retroactive date requested (see question #7), describe any practice outside your office location, such as rounds at a hospital and/or practice in another state: _____

35. Since the retroactive date requested (see question #7), have you ever treated or do you currently treat patients that were admitted to nursing homes by other physicians? Yes No

36a. Since the retroactive date requested (see question #7), have you ever utilized or do you currently utilize medical subcontractors or medical agents, on or off site, for purposes of providing professional medical services? Yes No

If so, explain who and under what circumstances? _____

36b. Since the retroactive date requested (see question #7), have you ever utilized or do you currently utilize remote off-site radiology services to read films on behalf of yourself, or your practice, including but not limited to teleradiology services?

Yes No

If so, explain who and under what circumstances? _____

V. HOSPITAL AFFILIATIONS

37a.	Hospitals granting you privileges	Nature of privileges	% work in each	# of years
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

37b. If you do not have admitting privileges, please describe in detail your procedure for handling your patients who may require immediate in-patient care.

37c. Have any hospital staff or clinical privileges been revoked, restricted, suspended, limited, refused or subject to investigation? Yes No If so, explain _____

38. Since the retroactive date requested (see question #7), have you ever provided, emergency care? Yes No

If YES, was or currently is your work for your own patients only? Yes No

Was your work required for staff privileges? Yes No

Was there a written contract or agreement? (If YES, attach copy) ... Yes No

Was insurance coverage provided by the facility for your work? Yes No

OTHER AFFILIATIONS

39. Do you have any affiliations where you practice medicine or have an ownership interest outside your private office practice listed in questions 18b (i.e., clinics, laboratories, etc.)? Yes No
- a. If YES, Name of facility _____ Department _____
- Are you: Sole owner Executive officer
 Partial owner Physician with teaching responsibilities
 Medical director Department or ancillary service director
 Administrator
- b. type of contractual agreement: _____ Oral Written (submit copy)
- c. How many hours per week in the capacity(ies) above? _____ hours per week
- d. Is insurance coverage provided by the entity? _____ Yes No
 If NO, is coverage being sought under this policy? If YES, give full details of practice.

PROCEDURES

40. Since the retroactive date requested (see question #7), have you ever performed or do you currently perform any surgery in your office? Yes No

If yes, please list types of procedures:

Does your office have emergency resuscitation equipment? _____ Yes No

41. Since the retroactive date requested (see question #7), have you performed or do you currently perform in other non-hospital facilities? _____ Yes No

If YES, facilities:

surgical procedures:

_____	_____
_____	_____
_____	_____

42. Since the retroactive date requested (see question #7), in the course of surgery described above, has there ever been or currently is there general anesthesia administered:

by you? _____ Yes No

by others? _____ Yes No

43. Since the retroactive date requested (see question #7), have you ever personally provided or do you currently provide pre-operative examination and post-operative care for all surgical patients? Yes No

If NO, please explain:

44. Since the retroactive date requested (see question #7), have you ever obtained or do you currently obtain written (please attach copy) or verbal informed surgical consent from your patients?

45. Since the retroactive date requested (see question #7), please indicate by marking Yes which procedures you have ever performed or currently perform. Provide explanations in the Notes Section where necessary.

<input type="checkbox"/> Yes <input type="checkbox"/> No Abortions _____ Number of Therapeutic Abortions Over Last 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No Acupuncture <input type="checkbox"/> Therapeutic/ Local Anesthetic <input type="checkbox"/> General Anesthetic <input type="checkbox"/> Yes <input type="checkbox"/> No Amniocentesis <input type="checkbox"/> Yes <input type="checkbox"/> No Coronary Angiography <input type="checkbox"/> Yes <input type="checkbox"/> No Cerebral Angiography <input type="checkbox"/> Yes <input type="checkbox"/> No Angioplasty <input type="checkbox"/> Yes <input type="checkbox"/> No Arthroscopy <input type="checkbox"/> Yes <input type="checkbox"/> No Arteriography <input type="checkbox"/> Yes <input type="checkbox"/> No Hospital Surgery as Primary Surgeon <input type="checkbox"/> Yes <input type="checkbox"/> No Assisting in Surgery <input type="checkbox"/> Own Patients Only <input type="checkbox"/> Own & Other Than Own Patients <input type="checkbox"/> Yes <input type="checkbox"/> No Spinal Surgery If yes, list types and Frequency: _____ _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Blepharoplasty –Brow Lifts <input type="checkbox"/> Cosmetic <input type="checkbox"/> Reconstruction <input type="checkbox"/> Yes <input type="checkbox"/> No Breast Implants <input type="checkbox"/> Cosmetic <input type="checkbox"/> Reconstruction <input type="checkbox"/> Yes <input type="checkbox"/> No Cosmetic Surgery* <input type="checkbox"/> Major <input type="checkbox"/> Minor <input type="checkbox"/> Yes <input type="checkbox"/> No Scar Revisions <input type="checkbox"/> Yes <input type="checkbox"/> No Sclerotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No Suction Lipectomy* <input type="checkbox"/> Yes <input type="checkbox"/> No Bronchoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No Blepharopigmentation <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac Catheterization <input type="checkbox"/> Right Heart <input type="checkbox"/> Left Heart <input type="checkbox"/> Yes <input type="checkbox"/> No Cataract Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Cryosurgery (other Than external lesions) <input type="checkbox"/> Yes <input type="checkbox"/> No ERCP <input type="checkbox"/> Yes <input type="checkbox"/> No Electroconvulsive Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No Endoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No Fracture Reductions <input type="checkbox"/> Open <input type="checkbox"/> Close <input type="checkbox"/> Yes <input type="checkbox"/> No Phenol / Chemical Facial Peel	<input type="checkbox"/> Yes <input type="checkbox"/> No Diagnostic Embolization <input type="checkbox"/> Yes <input type="checkbox"/> No General/Spinal/Caudal Anesthesia <input type="checkbox"/> Pulse Oximetry <input type="checkbox"/> End Tidal CO ² Analyzer <input type="checkbox"/> Yes <input type="checkbox"/> No Hair Transplants <input type="checkbox"/> Scalp Excision / Transplantations <input type="checkbox"/> Plug Technique / Minigraph <input type="checkbox"/> Yes <input type="checkbox"/> No Laparoscopy Cholecystectomy <input type="checkbox"/> Yes <input type="checkbox"/> No Laparoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No Laser Surgery List types and procedures: _____ _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Liposuction <input type="checkbox"/> Yes <input type="checkbox"/> No Lymphangiography <input type="checkbox"/> Yes <input type="checkbox"/> No Lithotripsy <input type="checkbox"/> Yes <input type="checkbox"/> No Major Gynecological Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Myelography <input type="checkbox"/> Yes <input type="checkbox"/> No Needle Biopsy <input type="checkbox"/> Yes <input type="checkbox"/> No Nerveblocks <input type="checkbox"/> Lumbar Epidural Steroid <input type="checkbox"/> Paraspinal <input type="checkbox"/> Sciatic <input type="checkbox"/> Facet <input type="checkbox"/> Paravertebral <input type="checkbox"/> Peripheral <input type="checkbox"/> Occipital <input type="checkbox"/> Triggerpoint Injection <input type="checkbox"/> Yes <input type="checkbox"/> No Paracentesis <input type="checkbox"/> Yes <input type="checkbox"/> No Phlebography <input type="checkbox"/> Yes <input type="checkbox"/> No Pnuemoencephalography <input type="checkbox"/> Yes <input type="checkbox"/> No Radial/Laser Keratomy <input type="checkbox"/> Yes <input type="checkbox"/> No Radiopaque Dye <input type="checkbox"/> Non-Toxic Only <input type="checkbox"/> Yes <input type="checkbox"/> No Sigmoidoscopy <input type="checkbox"/> Less than 60 cm <input type="checkbox"/> Greater than 60cm <input type="checkbox"/> Yes <input type="checkbox"/> No Colonoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No Polypectomy <input type="checkbox"/> Yes <input type="checkbox"/> No Gastrointestinal Endoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No Urological Implants <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Therapy <input type="checkbox"/> Yes <input type="checkbox"/> No Sex-Reassignment Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Silicone Injections <input type="checkbox"/> Yes <input type="checkbox"/> No Skin Flaps / Grafts <input type="checkbox"/> Cosmetic <input type="checkbox"/> Reconstruction <input type="checkbox"/> Yes <input type="checkbox"/> No Swan-Ganz Catheterization	<input type="checkbox"/> Yes <input type="checkbox"/> No Tubal Ligations Eivasectomies <input type="checkbox"/> Yes <input type="checkbox"/> No Vasectomies <input type="checkbox"/> Own Patients Only <input type="checkbox"/> Own & Other Than Own Patients <input type="checkbox"/> Yes <input type="checkbox"/> No Weight Control Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Weight Control Therapy <input type="checkbox"/> Drugs, list below _____ _____ _____ % of practice <input type="checkbox"/> Yes <input type="checkbox"/> No Gastric Bubble <input type="checkbox"/> Yes <input type="checkbox"/> No Gastric Stapling <input type="checkbox"/> Yes <input type="checkbox"/> No Prenatal Practice <input type="checkbox"/> See Patients during First & Second Trimester <input type="checkbox"/> See Patients but do Not Perform Delivery <input type="checkbox"/> See Patients to Term and Perform Delivery <input type="checkbox"/> Yes <input type="checkbox"/> No Normal Obstetrical Deliveries _____ per year <input type="checkbox"/> Yes <input type="checkbox"/> No Cesarean Section _____ per year <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Related Fields (If yes, complete Form C) <input type="checkbox"/> Yes <input type="checkbox"/> No Other Procedures Not Customary to Your Specialty. Please list: _____ _____ _____ * If other than board certified or board Eligible Plastic Surgeon provide proof of training. ** Provide proof of training if received outside your residency
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46. Are you seeking coverage during your retroactive period for any procedures and/ or medical practice which you did not indicate in question # 47?

Yes No

If YES, please list all procedures for which you seeking retroactive coverage that you did not indicate in question # 46 in the Notes Section.

47. ANESTHESIOLOGISTS

(Please complete **Form F**)

DENTAL RELATED FIELDS

(Please complete **Form C**)

PODIATRISTS

(Please complete **Form I**)

48. **FAMILY PRACTICE/GENERAL PRACTICE** – Provide a complete written description of your practice, including all procedures. (also, please complete **Form E**)

49. GENERAL, THORACIC, VASCULAR and CARDIAC SURGERY

Since the retroactive date (see question #7) requested have you ever performed or do you currently perform organ transplants? Yes No

50. OBSTETRICS AND GYNECOLOGY

(Please complete **Form B**)

51. **OPHTHALMOLOGY** – Provide a complete written description of your practice, including all procedures. (Also, please complete **Form D**)

VI. CLAIM, INCIDENT AND INSURANCE HISTORY

IMPORTANT: MPM will rely on the accuracy of all statements made in determining whether or not to issue a policy of insurance. Incomplete or incorrect information given by you, in the event of a claim, may, in MPM's discretion, lead to the denial of insurance coverage by MPM. Alternatively, MPM may, in its discretion require an increased premium retroactively in the event of a claim arising from information not fully and completely disclosed or in the event of the discovery of information not fully and completely disclosed at the time of this application.

52. List professional liability insurers for the past 10 years:

Company	Policy Number	Limits	From	To	Type of coverage form?	
					Occurrence	Claims Made
_____	_____	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>

53. **Whether or not you are applying for retroactive coverage, please provide a copy of your current policy including all endorsements; state the annual premium amount; and provide a copy of the declaration page.**

54. **Have you ever:**

a. been investigated, asked to resign or involved in official or nonofficial proceedings brought by a hospital, managed care organization or other healthcare facility to deny, limit, suspend, nonrenew or revoke your privileges? Yes No

b. had your membership in any professional society or association ever been suspended or revoked? Yes No

c. had your license to practice medicine or your permit to dispense or prescribe drugs been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? Yes No

d. been notified to respond to, appear before or been investigated by any licensing or regulatory agency on a complaint of any nature, including, but not limited to, unprofessional or unethical conduct? Yes No

- e. been charged with or convicted of a felony or misdemeanor other than minor traffic violations? Yes No
- f. been evaluated, treated or hospitalized for any of the following: Yes No
 alcoholism central nervous system stimulants or depressants
 mental or emotional disorders drug addiction
- g. had or become aware of having an illness or physical disability which impairs or could impair your ability to practice any aspect of medicine? If YES, please submit a letter from your treating physician addressing your state of health and whether any condition exist which could adversely affect the practice of your medical specialty Yes No
- h. had Medicare/Medicaid fraud charges filed against you? Yes No
- i. signed any contractual agreement in which you have agreed to indemnify (hold harmless) other persons or entities? (If so, please note that MPM is not a party to Indemnification or hold harmless agreements under it's policies and, accordingly, will not be responsible for any liability incurred under such agreements) Yes No
- j. been refused board certification? Yes No
- k. been under punitive or disciplinary observation, preceptorship or sponsorship in a hospital? Yes No
- l. been contacted by any hospital committee or group (other than an official peer review committee) that has reviewed (i) any issue regarding your delivery of medical services which you know or should have reason to know was of significant concern to a hospital where you have privileges, or (ii) any issue which arose out of any unexpected occurrence involving death or serious physical or psychological injury? Yes No
- m. had a grievance filed against you with any medical society, or have you been censured or received a private reprimand from any such organization? Yes No
- n. had any professional liability insurance refused, cancelled, or non renewed? Yes No

If you answered YES to any of the above questions #54a through 54n, please explain in the Notes Section of this application.

55. **Have you ever:**
- a. been a party to a lawsuit alleging medical malpractice or negligence? Yes No
- b. had a claim for medical malpractice settled on your behalf with or without the filing of a lawsuit? Yes No
- c. received a letter from an attorney wherein the attorney states that you may have committed malpractice or acted negligently in the treatment of a patient? Yes No
- d. received a letter from a patient or relative of the patient wherein the patient or relative of the patient claims that you committed malpractice or acted negligently in the treatment of a patient? Yes No
- e. given a deposition in a lawsuit where you were not a party in the lawsuit but your employer was a party to the lawsuit and the lawsuit alleged medical malpractice? Yes No

If you answered YES to any of the above questions #55a through 55e, please complete Form A-claim/incident report for each affirmative answer.

56. Do you know of any facts or circumstances relating to or arising out of any patient care provided by you or others at your request or referral or direction which could possibly result in a claim being made against you, or your corporation, even if it is only a remote possibility in your mind and even if you believe the claim or suit would be without merit? Yes No

If you answered YES to above questions #56, please complete Form A-claim/incident report.

57. Are you aware of any of the following circumstances:

- a. A request for records from a patient and/or attorney related to an adverse outcome? Yes No
- b. A letter communication from a patient, patient's representative, friend, relative or attorney regarding your medical treatment of a patient? Yes No
- c. Intra-operative complications or other complications resulting in death, paralysis or other significant disabilities? Yes No
- d. Have any unexpected or potentially problematic results or incidents occurred in the past five years in the following categories?
 - i. Cardiac arrest Yes No
 - ii. Postoperative coma Yes No
 - iii. Postoperative neurological deficits Yes No
 - iv. Unexpected death within 48 hrs. postoperatively Yes No
 - v. All others _____
- e. A request for the medical records of a patient who was deceased? Yes No
- f. A request for medical records of a patient who was admitted to a hospital as a result of an adverse reaction to medicine that you prescribed? Yes No

If you answered YES to any of the above questions #57a through 57f please complete Form A-claim/incident report for each affirmative answer.

58. Do you know of any facts or circumstances relating to or arising out of any patient care provided by you or others at your request or referral or direction which resulted in a patient, or a patient's representative, friend or relative becoming dissatisfied with the outcome of your procedure, treatment or diagnosis? Yes No

If you answered YES to the above question #58, please explain in the Notes Section.

59. Do you know, of any facts or circumstances relating to or arising out of any patient care provided by you or others at your request, referral or direction which have resulted in a claim or lawsuit that has not been reported to your current or prior professional liability carrier? Yes No

If you answered YES to the above question #59, please complete Form A-claim/incident report.

60. Do you know, of any facts or circumstances relating to or arising out of any patient care provided by you or others at your request, referral or direction which have resulted in a claim or lawsuit that has been reported to your current or prior professional liability carrier? Yes No

If you answered YES to the above question #60, please complete Form A-claim/incident report.

61. Other than the incidents, events and claims disclosed on Form A attached hereto, since the retroactive date requested, there are no circumstances, acts, errors or omissions, known to me or of which I should reasonably be aware which could result in a professional liability claim against me or against any entity of which I am an employee, equity holder, officer or director.

Signature: _____ **Date:** _____

I understand and agree that any Policy issued to the applicant hereunder will have been issued in reliance upon the representations made herein which are warranted to be true and complete. I further understand and agree that failure to provide true and complete responses to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any Policy issued.

THIS APPLICATION WILL BE ATTACHED TO AND BECOME A PART OF YOUR POLICY THAT MAY BE ISSUED.

I hereby declare that my statements in this application and any attachments hereto are true and accurate and complete, and that I have not withheld any information that is reasonably likely to influence the judgment of the company in considering this application for professional liability insurance. Up to the effective date of the policy for which I am applying, I agree to immediately notify Missouri Professionals Mutual (“Company”) of any information, fact or circumstance that amends, modifies or changes any information contained in this application. I further agree to be bound by the underwriting guidelines of Missouri Professionals Mutual.

In accordance with the provisions of Section 383.035, RSMo, I hereby state that I acknowledge and understand that the Company has published standard rates for coverage and that due to underwriting, marketplace, type of practice, area of practice and past history reasons I may not be charged such rate by the Company for coverage and may be charged an increased rate. I hereby acknowledge and consent to such increased rate to be charged by the Company for medical malpractice coverage under the Company Policy.

I hereby authorize the present and prior professional liability insurance carriers and any and all attorneys who have represented me in connection with any claim of professional liability to release to the Company upon its request for information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon my acceptability to the Company as a professional liability insurance risk.

I also authorize all medical associations and medical societies in which I am or have been a member, all hospitals in which I now hold or have held staff privileges, the State Board of Medical Examiner for the State of Missouri and any other State in which I have practiced, or resided, and any and all entities and physicians having information regarding me, to release to the Company upon its request any information any such person or entity may have which in the judgment of any such person or entity or the Company may have a bearing upon my acceptability to the Company as a professional liability insurance risk.

I hereby release and agree to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Company, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

I hereby acknowledge that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to me. I agree that I shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and I hereby expressly waive any right I may have to compel such disclosure.

I further agree that the Company and all persons and organizations described above may rely upon a photostatic copy of the foregoing authorization, which shall be of equal validity with the signed original.

Acceptance of advance payment does not bind the Company to provide insurance.

I acknowledge that I am responsible for payment of all unpaid assessments and premiums regardless of whether anyone has agreed to pay premiums on my behalf.

I authorize release and exchange of information involving past and future underwriting and claims matters, including but not limited to investigations for material information on my reputation and fitness to practice medicine.

I understand and acknowledge upon acceptance of this application by the Company, this application shall become a part of the Policy and operate as a contract between the insured and the Company.

With the submission of this 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 from any and all liability, the Company, its directors, officers, agents, members, employees, Missouri Professional Management, L.L.C., its directors, officers, agents, members, employees and other authorized representatives, for any acts pertaining to my application for insurance, including ultimate cancellations, rejection, or approval for insurance, and any communications, reports, records, statements, documents, disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

I hereby declare and warrant that the foregoing statements and particulars are, to the best of my knowledge and recollection, complete and correct and that I have not suppressed or misstated any material facts. I understand that this is an application for insurance and not an insurance binder.

I acknowledge that acceptance into the Company's insurance program is not a right of every applicant for insurance, and that my application will be evaluated by authorized management personnel and/or the Company's underwriting committee. Submission of a payment or deposit with this application and provisional receipt of such payment by the Company does not constitute acceptance for insurance nor the creation of an insurance contract. If an applicant is not accepted, any such payment shall be returned to the applicant.

By my signature on this Application, I hereby, as of the date I shall become a member, (or in the event this is a renewal application, the date provided below) constitute and appoint Timothy H. Trout or in his absence the then current Chairman of the Board of Directors of the Company as my proxy with full power of substitution to represent the undersigned by casting by proxy the vote to which the undersigned is entitled at all general, annual and/or special meetings of the members of the Company to be held between the date I shall become a member and the date thirty-six (36) months from the date of my signature below, at which time this proxy shall expire unless extended by the undersigned, whenever the undersigned is not personally present, or at any adjournment thereof, as if the undersigned were personally present; and the undersigned hereby ratifies and confirms all that may be done by virtue hereof. This proxy may be revoked by the member delivering a written notice revoking this proxy to the Secretary of the Company or as provided by law, but in the absence of such revocation it shall remain valid during the time herein specified; nor shall failure to use this proxy render it void.

Upon becoming a member of the Company I agree to accept and will be bound by the Articles of Association and the By-laws of the Company, as both may be amended from time to time, including provisions with respect to the obligation to pay assessments as and when charged. I agree to the duties and obligations of a member as provided in the above referenced Articles and By-laws, including the obligation to pay assessments as and when charged, and/or levied, during the period for which my policy is written, regardless of any intervening termination of said policy. I agree that any representative appearing on my behalf and appointed by me has authority to do so.

I authorize the Company to release and discuss all information contained in this application and any information relating to any future claim or incident to the person I have designated as my contact in this application.

Signature: _____

Date: _____

Broker (Producer) Signature: _____

Date: _____

Broker License No: _____

An underwriter may contact you for further information or clarification.
The Company acknowledges receipt of this application.

Missouri Professionals Mutual

By: _____

Date: _____



**Form A – Supplement to Application
Claim/Incident Report**

Please complete this form to report any facts or circumstances relating to any patient care provided by you or others at your request or referral which could possibly result in a claim, even if it is only a remote possibility in your mind, and even if you believe the claim or suit would be without merit. Please otherwise utilize this form to respond to any questions on your application where you responded with a "Yes." [Attach copies of patients' charts, operative notes or other documents as appropriate to explain the facts and circumstances.]

If there has been more than one claim or incident, please photocopy this form. Attach additional sheets if needed. All questions must be answered or marked Not Applicable (N/A).

Section I.

Use this section for reporting a Claim.

1. Name of Patient: _____

Age: _____ Sex: _____

Address: _____

City/State/Zip: _____

2. Date Reported to Insurance Company: _____

3. Name of Insurance Company: _____

4. Date of Claim: _____

5. Location of Claim: _____

6. Description of Claim: _____

7. Extent and Nature of the Injury: _____

8. Present Condition of the Patient: _____

9. Extent, Nature and Type of Claim: _____

10. State how and when you became aware of this Claim: _____

11. Other physicians, insureds, professionals or entities involved: Please attach a separate piece of paper if necessary.

Name: _____

Address: _____

Telephone Number: _____

Name: _____

Address: _____

Telephone Number: _____

12. Other Witnesses: Please attach a separate piece of paper if necessary.

Name: _____

Address: _____

Telephone Number: _____

Name: _____

Address: _____

Telephone Number: _____

13. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this Claim?

Yes No

14. Status of Claim (check applicable answer):

Suit threatened, no action taken Suit Settled Out-of-Court Awaiting Med/Dental Screening Panel Review

Suit filed but dropped by claimant a. Date claim paid _____
b. Amount paid _____ Awaiting mediation

Summary Judgment in your Favor c. Did you want to settle this claim? Yes No Awaiting court action
Reserve Amount: _____

Court outcome in your favor Court outcome in favor of plaintiff
 Jury Verdict Jury Verdict
 Directed Verdict Directed Verdict
Amount of Loss Payment: \$ _____

15. Name and address of the attorney assigned to your case: _____

16. To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?

Yes No
If "yes," list settlement amount: \$ _____

17. Please provide any other relevant information: _____

Signature: _____

Print Name: _____

Date: _____

Section II.

Use this Section for reporting an Incident.

1. Name of Patient: _____

Age: _____ Sex: _____

Address: _____

City/State/Zip: _____

2. Date Reported to Insurance Company: _____

3. Name of Insurance Company: _____

4. Date of Incident: _____

5. Location of Incident: _____

6. Description of Incident: _____

7. Extent and Nature of the Injury: _____

8. Present Condition of the Patient: _____

9. Extent, Nature and Type of Claim Anticipated: _____

10. State how and when you became aware of this Incident: _____

11. Other physicians, insureds, professionals or entities involved: Please attach a separate piece of paper if necessary.

Name: _____

Address: _____

Telephone Number: _____

Name: _____

Address: _____

Telephone Number: _____

12. Other Witnesses: Please attach a separate piece of paper if necessary.

Name: _____

Address: _____

Telephone Number: _____

Name: _____

Address: _____

Telephone Number: _____

13. Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this Incident?

Yes No

14. Please provide any other relevant information: _____

Signature: _____

Print Name: _____

Date: _____

Form B – Supplement to Application

Supplemental Questionnaire for Obstetrics and Gynecology

1. Since the retroactive date requested (see question #7), have you limited limit your practice to Gynecology only.....
..... Yes No

If Yes, on what date did you limit your practice to Gynecology only: _____

Do you currently limit your practice to Gynecology only: Yes No

2. Since the retroactive date requested (see question #7), have you ever or do you currently employ(ed) or ___
supervise(ed) any nurse midwives?..... Yes No

3. How many deliveries do you perform per year and in the last 5 years? _____

What percentage of your deliveries are: C Section _____%
Vaginal _____%

4. Since the retroactive date requested (see question #7), have you ever terminated or do you currently terminate
pregnancies by any means? Yes No

5. Since the retroactive date requested (see question #7), have you ever performed or do you currently perform
abortions Yes No. If yes, how many abortions do you perform per year and how many abortions have you
performed in the past 5 years?

6. Do you now or have you ever performed indicated abortion(s) or third trimester dilation and extraction?
 Yes No If Yes, how many have you performed? _____

7. If you answered Yes to question 5 and/or 6, were all these procedures performed in a clinic or hospital setting?
 Yes No

8. Have you ever delivered a child or participated in the delivery of a child in the last 10 years where the child was
diagnosed as having any kind of brain damage, mental retardation or neonatal seizures?

9. Have you ever delivered a child or participated in the delivery of a child in the last 10 years where the child was
diagnosed as having seizures in the first 72 hours of the child's life?

10. Have you ever delivered a child or participated in the delivery of a child in the last 10 years where the parents
complained of the baby having shoulder dystocia or brachial plexus injury?

11. Have you ever delivered a child or participated in the delivery of a child in the last 10 years where a placenta abruptia
occurred and the mother died?

12. Have you delivered any babies in the last 5 years that have died? ____ Yes ____ No

13. Have you reported any and all sub-optimal results or outcomes to your current or prior carriers?
____ Yes ____ No

If you answered yes to any of these questions numbered 8-13, above, please complete Form A and report these
incidents immediately to your current or prior carrier.

Form C – Supplement to Application

Supplemental Questionnaire for Dental Related Fields

1. a. Since the retroactive date requested (see question #7), have you ever administered or do you currently administer general anesthesia? Yes ___ No ___
- b. If "YES", where is the anesthesia administered? Office ___ Hospital ___
Surgical Center _____ Other _____
- c. Since the retroactive date requested (see question #7), have you ever administered or do you currently administer intravenous or intramuscular sedation? Yes ___ No ___
If "YES", please list the drugs you utilize for this purpose. _____

- d. Do you ever or have you ever rendered the patient unconscious? Yes ___ No ___ If "YES", provide names of anesthetics used and quantities in which they are usually administered.

- e. Since the retroactive date requested (see question #7), have you supervised or do you currently supervise CRNAs? Yes ___ No ___ If "YES", where do you supervise the CRNAs? Office ___ Hospital ___ Surgical Center ___ Other _____
- f. Did the CRNA/CRNAs carry and do they now separate liability insurance? Yes ___ No ___
If "YES", please provide a photocopy of the insurance policy.
- g. Since the retroactive date requested (see question #7), have you ever performed or do you currently perform dentistry on patients who have been administered general anesthesia?
Yes ___ No ___
- h. Since the retroactive date requested (see question #7), have you used or do you currently use nitrous oxide or any other anesthetic as an "analgesic" where patients are not rendered unconscious? Yes ___ No ___
If "YES", provide names of anesthetics used: _____

- i. Are you fully trained in CPR? Yes ___ No ___
When Certified _____ When Recertified _____
- j. Have you received any training in intubation? Yes ___ No ___
- k. Since the retroactive date requested (see question #7), have you ever employed or do you currently employ a Dental Hygienist? Yes ___ No ___
If "YES", does/did the Dental Hygienist provide his/her own liability insurance? Yes ___ No ___
- l. Since the retroactive date requested (see question #7), have you always and do you currently directly supervise the Dental Hygienist? Yes ___ No ___
2. Since the retroactive date requested (see question #7), have you ever performed or do you currently perform any reconstructive surgery? Yes ___ No ___
If "YES", explain in detail? _____

FORM D-SUPPLEMENT TO APPLICATION

**OPHTHALMOLOGY PROCEDURES
QUESTIONNAIRE**

If your specialty is Ophthalmology, please complete the following. Since the retroactive date requested (see question #7), please indicate by marking Yes which procedures you have ever performed or currently perform:

Ophthalmology – No Surgery

- Yes No Eye Infections
- Yes No Foreign Body Removal
- Yes No Refractions
- Yes No Tonometry

Ophthalmology – Minor Surgery

- Yes No Blepharoplasty -- Functional
- Yes No Cataract Surgery
- Yes No Chalazion Excision from Eyelid
- Yes No Iridectomy
- Yes No Intraocular Lens Replacement
- Yes No Laser, No Retinal Detachment
- Yes No Trabeculectomy

Ophthalmology – Major Surgery

- Yes No Blepharoplasty -- Cosmetic
- Yes No Corneal Transplants
- Yes No Enucleation
- Yes No Lid Repairs
- Yes No Permanent Lash Liner
- Yes No Radial Keratectomy (PRK)
- Yes No Laser in-situ Keratomileusis (LASIK)

FORM E – SUPPLEMENT TO APPLICATION

FAMILY PRACTICE PROCEDURES QUESTIONNAIRE

If your specialty is Family/General Practice, please complete the following. Since the retroactive date requested (see question #7), please indicate by marking Yes which procedures you have ever performed or currently perform:

Family Practice – No Surgery

- Aspirations of cyst of breast
Biopsies of lesions limited to the mucous membranes of the nose, mouth, Vagina, uterine cervix and rectum
Bone marrow biopsy
Chemotherapy (under the direction of an Oncologist)
Fine needle aspirations
Immobilization, excluding casting, or non-displaced fractures
Incising, excising, and/or suturing, for purpose of biopsy or otherwise, lesions limited to the skin and immediate subcutaneous tissue
Needle penetration of the skin and blood vessels
Paracentesis
Thoracentesis

Family Practice – Minor Surgery

- All Family Practice – no surgery procedures
Assisting in surgery
Circumcisions
Closed reduction of simple fractures
Colonoscopy (up to 65 centimeters, with or without IV Sedation)
Culdocentesis
Dilation and Curettage
Hemiorrhaphy
Insertion of IUD
Myringotomies
Nasal polypectomy
Office Gynecology
Other minor office procedures
Therapeutic abortion (1st trimester)
Vasectomy

Family Practice – Major Surgery

- All Family Practice – no surgery and minor surgery procedures
Analgesia, I.V. for surgical or other procedures
Anal fistulectomies
Appendectomy
A & P Repair
Cholecystectomies
Ectopic pregnancy
Elective cardioversion
Exchange transfusions
Hemorrhoidectomy
Hydrocelectomy
Hysterectomy, vaginal abdominal
Laparoscopy
Oophorectomy
Orchidectomy
Salpingectomy
Scalene Node biopsy
Tendon, repair
Tonsillectomy
Therapeutic abortion (up to 16 weeks)
Tubal ligation, open and laproscopic
Vein stripping

Approximately how many babies have you delivered since the retroactive date requested (see question 7) _____ (If more than 0 – Please complete Form B in its entirety)

Form F – Supplement to Application
Supplemental Questionnaire for Anesthesiology

1. Do you comply and have you always complied with the monitoring standards established by the American Society of Anesthesiologists? Yes No

2. Since the retroactive date requested (see question #7), have you practiced or do you currently practice medicine other than anesthesia? Yes No

If YES, please describe _____ Percent of time _____% Yes No

3. Since the retroactive date requested (see question #7), have you ever administered or do you currently administer anesthesia in a non-hospital setting? Yes No
If YES, please describe _____

4. Since the retroactive date requested (see question #7), have you ever or do you currently employ(ed) or supervise(d) any nurse anesthetists (CRNA)? Yes No

5. Since the retroactive date requested (see question #7), have you ever or do you currently employ(ed) or supervise(d) any inhalation therapists? Yes No

Form G – Educational Information

(To be completed in the event a current C.V. is not available)

Medical School: _____ from ___/___/___ to ___/___/___

Internship: _____ from ___/___/___ to ___/___/___

Residency: _____ from ___/___/___ to ___/___/___

Type of Residency: _____ Completed: ___ Yes ___ No

Other Training (fellowships, military service, etc.):

Name and type: _____ from ___/___/___ to ___/___/___

Name and type: _____ from ___/___/___ to ___/___/___

Form H - REQUEST FOR PART-TIME COVERAGE

Please complete this form if you are requesting part-time coverage.

1. Name: _____ M.D. D.O. Other _____
2. Policy #: _____
3. I am requesting coverage on a part-time basis effective (m/d/y): _____
4. Number of hours worked per week for which coverage is being requested: _____
(Practice hours consist of: Hospital rounds, on call hours involving patient contact, _____ communications with other physicians, patient visits, and charting.)
5. Patient Load Per Week: _____
6. Specialty for which you are applying for coverage: _____
7. My practice is reduced due to:
 Pregnancy or dependent care
 Semi-retirement: Date of Birth: _____
 Disability: Type _____ (Please submit explanation from treating physician)
 Majority of spent in a teaching capacity – Hours per week: _____
Place: _____
 Majority of employment insured through hospital: Name of Hospital: _____
 Majority of employment is in another state, which is insured elsewhere; State: _____
 Majority of practice insured through another carrier, entity or employer.
 Other (Please provide a description)
8. How long do you anticipate your coverage will be at these reduced hours?
9. Please submit proof of coverage for any employment listed above which is to be excluded on your MPM Policy.

**Form I – Supplement to Application
Supplemental Questionnaire for Podiatry**

1.	What type of policy is requested? <input type="checkbox"/> surgical <input type="checkbox"/> non-surgical <input type="checkbox"/> non-surgical / prior surgeries covered		
2.	Since the retroactive date requested (see question #7), please indicate which procedures you have performed or do perform: <input type="checkbox"/> Yes <input type="checkbox"/> No Osseous forefront surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Osseous rearfront surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Nail surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Incise and drain abscesses <input type="checkbox"/> Yes <input type="checkbox"/> No Excise verruca, molluscum contagiosum, cysts and other benign skin lesions		
3.	Since the retroactive date requested (see question #7), have you ever performed or do you currently perform post-operative care? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4.	Since the retroactive date requested (see question #7), have you ever performed or do you currently perform wound care services? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: _____% of practice _____% in office _____% other facility Identify other facility: _____ _____% of practice is devoted to diabetic patients		
5.	Since the retroactive date requested (see question #7), have you ever had or do you currently have an ownership interest in a wound care facility, other than your office? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes identify the facility: _____		
6.	For Non-Surgical Policyholders: If you provide or have provided post-operative care (other than for nails), provide the name of the surgeon and malpractice carrier: _____ _____		
7.	Since the retroactive date requested (see question #7), have you ever been or are you currently an employee of a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state the name(s) of the hospital: _____		
8.	Since the retroactive date requested (see question #7), have you ever been or are you currently on staff at any hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state the name(s) of the hospital: _____		
9.	Since the retroactive date requested (see question #7), have you ever obtained or do you currently obtain <input type="checkbox"/> written (please attach a copy) or <input type="checkbox"/> verbal informed surgical consent from your patients?		
10.	<table border="1"> <tr> <td data-bbox="261 1400 574 1509">Residency</td> <td data-bbox="574 1400 1489 1509"> From ___/___/___ to ___/___/___ Type of Residency: _____ Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> </table>	Residency	From ___/___/___ to ___/___/___ Type of Residency: _____ Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Residency	From ___/___/___ to ___/___/___ Type of Residency: _____ Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No		
11.	<table border="1"> <tr> <td data-bbox="261 1509 574 1619">Preceptorship</td> <td data-bbox="574 1509 1489 1619"> From ___/___/___ to ___/___/___ Type of Preceptorship: _____ Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> </table>	Preceptorship	From ___/___/___ to ___/___/___ Type of Preceptorship: _____ Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Preceptorship	From ___/___/___ to ___/___/___ Type of Preceptorship: _____ Completed: <input type="checkbox"/> Yes <input type="checkbox"/> No		
12.	Since the retroactive date (see question #7), requested, identify all podiatrists and/or medical doctors that you have been or are currently associated with: _____ _____		