PROASSURANCE
MISCELLANEOUS MEDICAL

Application for Professional Liability Coverage for Advanced Clinical Practitioners

Please attach copies of the following:
a) Currently valued five year loss runs, including claim supplemental for each loss
b) Copy of your current Professional Liability insurance Declarations Page
c) A copy of your Curriculum Vitae
d) A copy of all licenses and board certifications held by you
e) If applicable, Evidence of Cosmetic Training
f) If applicable, copy of policy Declarations Page or COI for entity

I. General Information:

1. Full Name of Individual Applicant: _____

2. Professional Designation: ☐ CRNA ☐ Nurse Practitioner ☐ Physician Assistant ☐ Nurse Midwife

3. Date of Birth: _____

4. US Citizen: Yes ☐ No ☐
   a. If No, what is your current status in the U.S?
   _____

5. Street Address_____ City: _____
   County: _____ State: _____ Zip: _____

6. Are you a(n):
   - ☐ Unincorporated Solo Practitioner
   - ☐ Incorporated Solo Practitioner
   - ☐ Professional Corporation (for profit)
   - ☐ Partnership: Professional Association
   - ☐ Employed Professional
   - ☐ Contracted Professional
   - ☐ Other:_____

   a. If seeking coverage for an above referenced entity, name of entity:
   _____

7. Gross Income of the Applicant: _____

8. If a Professional Association of Professional Corporation are you seeking coverage for this entity? If yes, Yes ☐ No ☐
   a. What is the name of this entity:_____
   b. Percentage of ownership: _____
   c. How many other professionals and/or staff are part of this entity: _____
   d. Do you contract with Independent Contractors to provide services on your behalf? Yes ☐ No ☐
   If yes, please provide details:
   _____

9. Do you own or operate any entities other than those above? Yes ☐ No ☐
   If yes, please provide details: _____

10. Do you or any organization authorized by you advertise your professional services in any manner? a. If Yes, please attach a copy of or provide links to advertisements.	Yes ☐ No ☐
11. Are you employed by the federal, state or local government (full or part time, including active military duty)? If yes, please explain: _____	Yes ☐ No ☐
12. If you are employed or contracted to provide professional services, provide entity name(s) and address(es): a. Entity Name: _____ Practice Address_____ b. Entity Name: _____ Practice Address_____ c. Entity Name: _____ Practice Address_____	
13. Is the entity(s) shown above presently covered by a medical malpractice policy? a. If Yes, please attach copy of the policy declarations page.	Yes ☐ No ☐

II. Licensure Information

14. Please provide the following information for all states in which you have practiced:

State	% of Practice	License #	Status
			☐ Active ☐ Inactive ☐ Temporary ☐ Pending
			☐ Active ☐ Inactive ☐ Temporary ☐ Pending
			☐ Active ☐ Inactive ☐ Temporary ☐ Pending
			☐ Active ☐ Inactive ☐ Temporary ☐ Pending
			☐ Active ☐ Inactive ☐ Temporary ☐ Pending

15. Please provide Federal DEA License # and status: _____

16. Does your practice comply in every way with the rules and regulations as set forth by the agency in your state charged with licensing and monitoring individuals in your profession?	Yes ☐ No ☐

III. Practice Profile

17. Please provide the percentage of your services that occur or are on behalf of the following entities/facilities.

Hospital – Emergency Department, ICU or Operating Room	%	Correctional Facility or ICE Detention Center	%
Hospital – Labor & Delivery	%	Medi-spa	%
Hospital - Other	%	Hospice	%
Ambulatory Surgery Center	%	Skilled Nursing Facility	%
University or College	%	Assisted Living Facility	%
Medical Clinic	%	Pre-K – 12 School	%
FTCA Clinic	%	Behavioral/Mental Health Facility	%
Group Homes/Residential Facilities – Adult	%	Physician Practice: Specialty: _____	%
Group Homes/Residential Facilities- Youth	%	Other	%

18. If services are provided in correctional facilities, please check which types of correctional facilities:
☐ Jail ☐ Prison ☐ Juvenile Detention Center ☐ Work Release ☐ Other Correctional Facility

19. If medi-spa services are provided, please check all procedure types performed:
☐ P-Shot/O-shot ☐ Juvederm/Botox/Fillers ☐ Thread Lifts ☐ HCG ☐ Dermaplaning
☐ Chemical Peels (Light) ☐ Chemical Peels (Medium to Heavy) ☐ Laser Hair Removal
☐ Microdermabrasion
☐ Other: _____

20. If services are provided in behavioral health facilities, please check which types of facilities:
☐ Inpatient Psychiatric ☐ Inpatient Substance Abuse ☐ Inpatient Dual Diagnosis ☐ Outpatient Facility

III. Practice Details

21. Do you render professional services directly to patients? a. If yes, please provide a description of services rendered: _____ b. What percentage of services are physician-supervised? _____ c. Who is the supervising/collaborating physician? _____ d. Is coverage requested for the supervising/collaborating physician? e. Is the supervising physician physically present? f. Describe frequency of physician consultation: _____ g. If applicable, describe your procedure for notifying your supervising physician of situations beyond the scope of your training or practice: _____	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
22. Do you provide any services via telehealth? a. If yes, please provide details:_____ b. Percentage of total practice: _____	Yes ☐ No ☐
23. What are your total average weekly practice hours? (Please confirm for each practice if more than one.): _____	
24. Do you elicit, record, and evaluate the health, psychosocial, and developmental history of the patient?	Yes ☐ No ☐
25. Do you order or perform diagnostic tests?	Yes ☐ No ☐
26. Do you discriminate between normal and abnormal findings in a history, physical examination, and diagnostic tests, and initiate referrals and consultations when needed?	Yes ☐ No ☐
27. Do you conduct informed consent discussions?	Yes ☐ No ☐
28. Do you dispense any drugs without the countersignature of a physician? a. If Yes, please explain: _____ b. If Yes, percentage that is Schedule II substances: _____%	Yes ☐ No ☐
29. Describe all procedures, treatments or duties you perform: _____ _____	
30. Do you provide services for persons 18 years of age or younger? a. If Yes, please confirm percentage of services _____%	Yes ☐ No ☐

31. Do you provide care or treatment to ventilator and/or tracheotomy patients? a. If yes, confirm percentage of services: _____% b. Where are the patients located: ☐ Hospital ☐ Skilled Nursing Facility ☐ Assisted Living Facility ☐ Private Homes	Yes ☐ No ☐
32. Do you provide any gynecological care? a. If yes, does your practice included pap smears?	Yes ☐ No ☐ Yes ☐ No ☐
33. Do you perform any maternity care: prenatal, intrapartum, postnatal, midwifery? a. If yes, please provide details: _____ _____	Yes ☐ No ☐
34. Do you perform abortions? a. If yes, medication/pill only _____ surgical _____	Yes ☐ No ☐
35. Do you perform, order, or evaluate prenatal genetic testing?	Yes ☐ No ☐
36. Do you perform any PRP Therapy?	Yes ☐ No ☐
37. Do you perform any Stem Cell Therapy?	Yes ☐ No ☐
38. Does you practice include Concierge Medicine?	Yes ☐ No ☐
39. Do you provide services to any collegiate or professional athletes? a. If yes, please provide details: _____ _____ b. Percentage of total practice: _____	Yes ☐ No ☐
40. Do you perform complex wound care?	Yes ☐ No ☐
41. Do you perform psychiatric shock therapy?	Yes ☐ No ☐
42. Do you practice any holistic medicine (Acupuncture, Naturopathy, Chinese Medicine, Massage, etc.)? a. If yes, please provide details: _____ _____	Yes ☐ No ☐
43. Do you promote products, including Nutraceuticals, non-FDA approved drugs and/or supplements? a. If yes, please provide details: _____	Yes ☐ No ☐
44. Do you perform any Cosmetic/Aesthetic Procedures? a. If yes, please provide details: _____	Yes ☐ No ☐
45. Are you performing or assisting in any surgical procedures (CRNAs, answer questions in Section V.)? a. If yes, what surgical procedures (including minor surgeries), are you performing or assisting in? _____ b. Is anesthesia, other than topical or local infiltration administered by yourself or others? c. Do you perform or assist in any surgical procedure(s) in a professional office or similar non-hospital facility? d. If Yes to (b) or (c), please explain: _____ _____	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐

IV. Education and Training

46. Please complete the following table for your medical training:

	Institution/School and Location	Dates From/To	Degree/Specialty	Completed?
Undergraduate or Nursing School				Yes ☐ No ☐
Post-graduate training				Yes ☐ No ☐
Any additional Training				Yes ☐ No ☐
Other:_____				Yes ☐ No ☐

47. Are you a foreign medical or nursing school graduate? Yes ☐ No ☐

    a. If yes, please provide details:

    _____

48. What date did you begin your professional practice? _____

49. Are you a member of any professional societies or associations? Yes ☐ No ☐

    a. If yes, please list:

    _____

50. How many CE hours have you completed in the past 2 years? _____

V. Certified Registered Nurse Anesthetist (CRNA) Services Information Check N/A if doesn't apply

51. Please complete the following table advising percentage of each service that makes up your total practice. Total should be 100%.

Procedure	N/A	% of Practice last 12 Months	% of Practice next 12 Months	Procedure	N/A	% of Practice last 12 Months	% of Practice next 12 Months
Bariatric Surgery	☐			Dental/Oral Surgery	☐		
Plastic/Cosmetic Surgery	☐			Pediatric	☐		
Podiatric	☐			Obstetrical	☐		
Ophthalmologic	☐			Non-Surgical Pain Management	☐		
Spinal/Neurosurgery	☐			Orthopedic	☐		
Research or Experimental	☐			General Surgery	☐		
Other:_____				Other:_____			

52. Is 100% of your practice supervised by an anesthesiologist? Yes ☐ No ☐

53. If your practice is not supervised 100% by an anesthesiologist, please provide percentage supervised:

Supervisor	Percent	Supervisor	Percent
Another CRNA		Dentist/Oral Surgeon	
General Surgeon		Anesthesiologist	
Podiatrist		Bariatric Surgeon	
Plastic/Cosmetic Surgeon		Other:_____	

54. Please answer the following questions. For all "No" answers please attach an explanation.	
a. During administration of all anesthetics, do you use a pulse oximeter monitor?	Yes ☐ No ☐
b. During all anesthetics, is an electrocardiogram continuously displayed?	Yes ☐ No ☐
c. During all general anesthesia, do you use an end tidal CO2 monitor?	Yes ☐ No ☐
d. During all general anesthesia using an anesthesia machine do you use an oxygen analyzer with a low concentration limit alarm?	Yes ☐ No ☐
e. When ventilation is controlled by a mechanical ventilator, do you use a device equipped with a full set of safety alarms?	Yes ☐ No ☐
f. Do you test proper functioning of all equipment alarms prior to each use?	Yes ☐ No ☐
g. Are you present in the operating room throughout the conduct of all general anesthetics regional anesthetics and monitored anesthesia care?	Yes ☐ No ☐
55. During all anesthetics, how often is arterial blood pressure determined and evaluated?_____	
56. During all anesthetics, how often is circulatory function evaluated?	
57. What are your average weekly practice hours for all jobs, including on-call? _____	

VI. Prior Coverage and Policy Information

58. Please provide the following information pertaining to your past 5 years of professional liability coverage:

Insurer	Dates Covered	Limits of Liability	Deductible	Premium	Retroactive Date

59. Have you ever practiced without Professional Liability insurance in place?	Yes ☐ No ☐
60. Do you have Professional Liability insurance in place for work that you are not seeking coverage for under this policy? **If yes, please attach a copy of the policy Declarations page(s).**	Yes ☐ No ☐
61. Do you currently participate in or plan to participate in a state patient compensation fund, health care stabilization organization fund or other governmentally established malpractice liability funding mechanism? a. If Yes, which fund:_____	Yes ☐ No ☐

VII. Experience and Loss History Information

62. Please answer the following questions. **For all "Yes" answers please attach an explanation**.	
a. Has any licensing authority ever taken any action against you?	Yes ☐ No ☐
b. Have you ever had any professional license or license to prescribe and or dispense narcotics limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency?	Yes ☐ No ☐

c. Have you ever been charged with or convicted of a crime other than minor traffic violation(s)?	Yes ☐ No ☐
d. Have you ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness?	Yes ☐ No ☐
e. During the past five years, has any insurer ever canceled or non-renewed similar insurance?	Yes ☐ No ☐
f. Has any insurance been cancelled for nonpayment of premium by any insurance or finance company?	Yes ☐ No ☐
g. Have you had had your Medicaid, Medicare, or any other federal, state or local government health insurance program certification limited, suspended or revoked within the past five (5) years?	Yes ☐ No ☐
h. Have you ever been accused of any Medicaid, Medicare or any other federal, state or local government health insurance program fraud or abuse violations, or paid fines or penalties in connection with any such fraud or abuse violation?	Yes ☐ No ☐
i. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by a hospital, managed care organization or other healthcare organization to deny, limit, suspend, non-renew, or revoke your privileges?	Yes ☐ No ☐
j. Have you ever been accused of sexual misconduct or physical abuse of any kind?	Yes ☐ No ☐
63. Has any claim or suit for medical malpractice or professional liability ever been filed, or any claim otherwise been made against you including any partnership or joint venture of which you have been a member? **If Yes, please complete the Claim Supplemental below.** NOTE: WITHOUT PREJUDICE TO ANY OTHER RIGHTS, DEFENSES OR REMEDIES OF THE UNDERWRITER, IT IS AGREED THAT ANY CLAIM REQUIRED TO BE DISCLOSED IN RESPONSE TO QUESTION 63 IS EXCLUDED FROM THE PROPOSED INSURANCE.	Yes ☐ No ☐
64. Are you or anyone else proposed for this insurance aware of any occurrences, facts, circumstances, incidents, situations, act, error, omission or records request from a patient or their attorney which may result in a claim or suit? **If Yes, please provide details.**	Yes ☐ No ☐

GENERAL FRAUD WARNING

Any person who knowingly includes any false or misleading information on an application for an insurance policy or files a claim containing a false or deceptive statement may be guilty of insurance fraud and is subject to criminal and civil penalties.

Consent to Conditions of Consideration of the Application for Insurance

I understand that no coverage will be bound until after ProAssurance has reviewed my completed application and expressed its intention to provide coverage. Acceptance of payment is not an expression by ProAssurance of intent to provide coverage. If ProAssurance declines to offer coverage, my advance payment will be promptly returned to me.

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.

I understand that should any incident, injury or death occur to any patient while under my care subsequent to my signing and dating this application, I must notify ProAssurance or its authorized agent or broker in writing of such event.

Important: Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event of a claim, could lead to a denial of liability. The following section is an Applicant's Representation and Authorization from which requires your signature. Please read carefully.

Applicant's Representation and Authorization

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 and its subsidiaries or agents as a professional liability risk, including but not limited to closed, pending or anticipated claims, underwriting or other information.

I understand that third-party information, records or data regarding my practices, medical procedures and/or prescribing practices may be used for informational or underwriting purposes.

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 photocopy of this Authorization, which shall be of equal validity with the signed original.

I hereby declare and represent that the foregoing statements and particulars are complete, to the best of my knowledge and recollection, and that I have not willfully concealed, omitted, or misrepresented any material fact or circumstance concerning this insurance or the subject thereof.

Name (Printed): _____

Applicant's Signature: _____

Title: _____ Date: _____

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