

ALLIED HEALTHCARE PROVIDER
Application For Professional Liability Insurance
Employed by FLDIC Policyholder

**All statements below must be completed and all questions answered entirely.
Please type or print.**

**PLEASE DO NOT CANCEL YOUR PRESENT INSURANCE UNTIL A BINDER OR POLICY FROM THIS
COMPANY HAS BEEN RECEIVED AND IS IN EFFECT.**

1. Name _____ Social Security No. _____
2. Mailing Address _____
(Street/P. O. Box) (City/State/Zip)
3. Date of Birth _____ Place of Birth _____
4. Phone Number _____ Fax Number _____
E-Mail Address _____
5. Specialty / Scope of Duties

Nurse Anesthetist	Physician Assistant
Nurse Practitioner	Nurse Midwife

Please indicate whether the requested coverage is to be shared with the employer or separate from the employer.

I request: (select one) Separate limits from employer Shared limits with employer

*Describe role, activities and functions in the office, hospital or other settings (Please include a copy of applicable office protocols filed with the state)

Describe in detail the acts, tasks and functions that the applicant will be allowed to perform under indirect supervision (i.e. away from presence of supervising physician), and the safeguards (standing orders, backup arrangements, access via telephone, etc.) which have established for the protection of the patient.

6. I request an Effective Date of 12:01 a.m. on _____ Retroactive Date _____

I request policy limits of:

\$250,000/\$750,000

\$500,000/\$1,500,000

\$1,000,000/\$3,000,000

7. Type of Certification/License you currently hold. (**Attach copy to this application.**)

8. List the states where you practice and license numbers, if applicable:

State	% of Practice in State	License Number	License Status Active?	
			YES	NO
			YES	NO
			YES	NO
			YES	NO

9. Have you ever:

a. Had your license or certification suspended, denied, revoked, restricted, or been the subject of any disciplinary actions in any state? YES NO

b. Had your insurance for medical malpractice refused, cancelled, suspended, non-renewed, declined, or accepted on special terms? YES NO

c. Had any fee or professional relations complaints registered against you with your association(s), hospital(s), state licensing authority, or certifying body? YES NO

d. Been denied staff or hospital privileges or had privileges suspended, terminated or revoked? YES NO

e. Been treated or hospitalized for any mental or emotional disorders? YES NO

f. Incurred or become aware of having an illness or physical disability which impairs or could impair your ability to perform your duties? YES NO

g. Been charged with or convicted of a felony or misdemeanor other than minor traffic violations? YES NO

h. Been treated or hospitalized for use of any of the following:

- i. alcohol YES NO
- ii. narcotics YES NO
- iii. central nervous system stimulants or depressants YES NO

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE, PLEASE PROVIDE DETAILS ON A SEPARATE SHEET OF PAPER.

10. MEDICAL EDUCATION (Include a copy of your Resume or CV)

Institution _____
 State _____
 Degree/Certificate _____
 Dates from _____ to _____
 Date Graduated _____

Institution _____
 State _____
 Degree/Certificate _____
 Dates from _____ to _____
 Date Graduated _____

11. Describe any continuing medical education courses that you completed within the past two years.

12. WORK EXPERIENCE – (for the last 7 years)

a.

Employer	Address	Dates Employed

b. Do you treat patients at a nursing home, assisted living facility, jail or correctional facility?
 YES NO

If yes, please explain: _____

c. Do you want this FLDIC coverage to protect you for an exposure outside the scope of your employment by the FLDIC insured? YES NO

13. PRIOR PROFESIONAL LIABILITY INSURANCE INFORMATION

Carrier	Policy #	Policy Period	CM or OCC	Retro Date

(Attach copy of current coverage summary sheet.)

14. Have you ever been involved in a malpractice claim or suit, with an incident date, report date or close date occurring within the last ten (10) years, including any expression of an intent (i.e. closed records requests, incident reports and Notices of Intent, even if suit was never filed), or are you presently involved in malpractice litigation? YES NO

If Yes, submit a separate form for each case in the last ten (10) years

15. Do you know or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that any of the following circumstances might reasonably lead to a claim or suit being brought against you, even if you believe the claim or suit would be without merit:

a. A request for records from a patient and/or attorney related to an adverse outcome? YES NO

b. A letter or 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

16. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that a patient, or a patient's representative, friend or relative was dissatisfied with the outcome of a procedure, treatment or diagnosis? YES NO

17. Do you know, or is it reasonably foreseeable from the facts, reasonable inferences or circumstances that there are outstanding incidents, claims or suits **EVEN IF YOU BELIEVE THE OUTSTANDING CLAIM OR SUIT WOULD BE WITHOUT MERIT** that have not been reported to your current OR prior professional liability carrier? YES NO

If yes, please explain: _____

18. Has any other party (e.g. current or prior employer, physician, etc.) been the subject of a claim due to your actions? YES NO

(Complete supplementary claims information form on each claim or suit.)

SUPPLEMENTAL WAIVER AND RELEASE

I hereby acknowledge that the foregoing information constitutes my application for insurance with Florida Doctors Insurance Company (FLDIC). All statements are my own representations and are true, based upon my personal knowledge or what is reasonably foreseeable from the facts, reasonable inferences or circumstances related to a particular question on this application. I have not knowingly withheld any information that is calculated to influence the judgment of FLDIC in considering this application for professional liability insurance.

If accepted, I understand that insurance is being issued upon reliance of the truth of my representations. I understand that no insurance will be afforded unless and until this application is accepted by FLDIC and I am notified of said acceptance.

Further, I understand that a detailed inquiry and investigation of my professional background, competence and qualifications, which involves either underwriting or claims matters, may be conducted by FLDIC. I consent to any investigation or inquiry and authorize release and exchange of information related to me, without limitation, including favorable and unfavorable results, any state or hospital disciplinary actions or proceedings, medical malpractice coverage and claims, suits and performance records between the state medical licensing board, state medical association, county medical associations, prior insurance carriers, Physician Resource Network, individuals and FLDIC.

I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability that might be caused by or related to acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source. I understand that, if I am insured by FLDIC, re-verification of my credentials will be periodically required. Therefore, this authorization shall remain valid for so long as I maintain a business relationship with FLDIC, and any party furnishing information pursuant to this authorization is entitled to rely on the representation of FLDIC that this authorization is currently valid. I may cancel this authorization at any time, upon written notice to FLDIC.

Date _____ Signature of Applicant _____

Date _____ Signature of Employer _____

Employer's Medical License # _____ Employer's FLDIC Policy # _____

This application form duly completed together with any supplementary information must be signed in ink by the applicant. A signature on the form does not bind the applicant or FLDIC to complete the insurance.

(A photo static copy of this authorization shall be considered as effective and as valid as the original.)

FRAUD STATEMENT **Section 817.234(1)(b), Florida Statutes (if applicable)**

The statute requires the statement to contain in substance the following language: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony of the third degree.

**Florida Doctors Insurance Company
INCIDENT/CLAIM INFORMATION**

Patient Name _____

Your relationship to patient _____

Allegations _____

Date of Incident _____ Report Date: _____

Insurance Carrier: _____

Name of your defense attorney: _____

Other Defendants: _____

Location of Incident: _____

Condition and diagnosis at time of incident: _____

Dates and description of treatment rendered: _____

Present status of claim (check applicable answers):

Precautionary/Incident Report only:
Reserve Amount \$ _____

Suit threatened, no action taken

Out of court settlement:
Date Paid _____
Amount Paid \$ _____

Dropped by claimant

Summary judgment in your favor

Court settlement:
Date Paid _____
Amount Paid \$ _____

Court trial in your favor

Was the corporation sued? YES NO

Is claim pending? YES NO

If yes, Reserve Amount: \$ _____
If no, Payment Amount: \$ _____

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signed: _____

Date: _____