# Limited Professional Liability Insurance
# Application for Insured Paramedical Employees

ProAssurance
Treated Fairly

Submit to:
Scott Selman | Rich & Cartmill | PhysicianMalpracticeQuote.com Fax: 918-744-8429
2738 E 51st St Ste 400
Tulsa, OK 74105

**Requested Effective Date:** _____ /_____ /_____

Name (Last, First, MI): _____

SSN: _____ DOB: _____ Sex: Male ☐ Female ☐

Home Address: _____ City: _____ State: _____ ZIP: _____

Current Employer: _____ Telephone Number: _____

Business Address: _____ City: _____ State: _____ ZIP: _____

1. Profession:

| | | |
|---|---|---|
| ☐ Physician Assistant | ☐ Perfusionist | ☐ Certified Nurse Practitioner |
| ☐ Surgical Assistant | ☐ Optometrist | ☐ Certified Registered Nurse Anesthetist |
| ☐ Psychologist | ☐ Cytotechnologist | ☐ Emergency Medical Technician |
| ☐ Certified Nurse Midwife | ☐ Anesthesiologist Assistant | |

2. Is your employer insured by a ProAssurance Company? Yes ☐ No ☐

3. Have you ever:

A. Been convicted of a criminal offense? Yes ☐ No ☐

B. Been treated for (or recommended for treatment for) alcoholism, sexual, or drug addiction? Yes ☐ No ☐

C. Undergone psychiatric treatment? Yes ☐ No ☐

D. Had a complaint filed against you with any hospital or regulatory board? Yes ☐ No ☐

E. Had any professional license/permit or narcotics license investigated, suspended, revoked, restricted, or placed under probation? Yes ☐ No ☐

**If the answer to 3.A., 3.B., 3.C., 3.D., or 3.E. is yes, please provide complete details on a separate sheet of paper.**

4. Do you moonlight (work outside control of employer)? If yes, where? Yes ☐ No ☐

5. Do you hold the certification of licensure required in your state to practice your profession? Yes ☐ No ☐
If yes, where did you receive your training?

_____

6. Are you a member of any professional organization? If yes, please give details. Yes ☐ No ☐

7. Have any judgments ever been rendered against you or any out-of-court settlements in excess of $500 been made on your behalf from an incident alleging professional errors or omissions? Yes ☐ No ☐
If yes, please give details on a separate sheet. If available, please enclose copy of complaint.

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? Yes ☐ No ☐
If yes, please give details on a separate sheet. If available, please enclose copy of complaint.

9. Will you be scheduled to work at a separate location from your supervising physician? Yes ☐ No ☐
If yes, please give details on a separate sheet.

10. 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 ☐

11. Do you elicit, record, and evaluate a health, psychosocial, and developmental history of the patient? Yes ☐ No ☐

12. Do you order or perform diagnostic tests? Yes ☐ No ☐

13. Do you discriminate between normal and abnormal findings on the history, physical, examination diagnostic tests, initiate referrals and consultations when needed? Yes ☐ No ☐

14. Do you regulate or adjust medications and treatment as prescribed by or authorized by a licensed physician? Yes ☐ No ☐

15. Do you perform a physical examination? Yes ☐ No ☐
If yes, briefly describe techniques and instruments used: _____

_____

16. Do you conduct informed consent discussions? Yes ☐ No ☐

17. Describe any other procedures, treatments, or duties you perform:

18. Describe your procedure for notifying your supervising physician of situations beyond the scope of your training or practice:

19. Please list all states in which you are licensed along with each license number and renewal date:

| State | License Number | Renewal Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

20. 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 page
D. Claims history
E. Copies of your practice protocols

**GENERAL FRAUD WARNING – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.**

**ARKANSAS FRAUD WARNING – Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

**OKLAHOMA FRAUD WARNING – Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.**

## 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.

**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 Authorization To Release Information from which requires your signature. Please read 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: _____

Title: _____ Date: _____

## 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: _____

Shared Limits Coverage ☐

Separate Limits Coverage ☐

Note: Separate Limits Coverage is not available for Cytotechnologists.

_____ _____

Signature of Insured Physician/Supervising Physician Date

_____

Please Print Name