Carolinas HealthCare System

Application for Professional Liability Insurance
Instruction for Completion

Complete every section and indicate "n/a" or make notations if need; do not leave any section incomplete!

- Complete pages 2-9 of the application answering each question fully. Explain any gaps in dates of employment or insurance coverage. You may attach separate pages if necessary.

- **Pages 2-9 must be completed, signed, and returned with your Professional Liability Application**.

  If you are a current resident/fellow, you can obtain this information from the Risk Management Department at the facility where you completed your program.

- **Page 10** (Previous Professional Liability Insurance Coverage & Claim History)

  Complete the top portion of this form and forward to the appropriate carriers. Additional copies may be made as needed. **Please be sure your return a copy of this form with your application.**

- **Page 11** – Complete only if you have had any claims. Please check the appropriate box if there have been no claims. You may make copies of this form as needed.

- Include a copy of your **current and last five years** Certificates of Insurance. These can also be obtained from the Risk Management Department at your current facility.

  In order to allow appropriate time for processing your application, please submit this application as soon as possible.

- Please request a copy of your loss-run report for your current coverage and the past five years. You can request this directly from the carrier. The carriers are required to respond to your request within two weeks. This information can be sent directly to your provider placement coordinator or you may email/fax the information once received. Please do not delay return of your application while awaiting this information from your carrier(s).

Failure to include the signed release and certificates may delay your start date

.

It is important that your application and prior insurance information be received timely. Carolinas HealthCare System cannot provide professional liability for you until all information is received and processed.

CAROLINAS HEALTHCARE SYSTEM
(Here in referred to as CHS)

PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY
APPLICATION FOR INDIVIDUAL PHYSICIANS /CERTIFIED NURSE MIDWIFE

GENERAL INFORMATION

1. Name of CHS Facility/Practice: _____

2. Address: _____

3. Applicant Name:_____

4. Address: _____
   Street City County State Zip

5. Telephone Number: _____ Fax Number: _____

6. Date of Birth: _____ Social Security #: _____

EDUCATION

7. Medical School_____ Degree_____ Month_____ Year_____

   a. If a foreign medical school grad., do you have an ECFMG Certificate or a Fifth Pathway Certificate **Yes** ☐ **No** ☐

   Indicate which certification was obtained and year certified. ECFMG☐ Fifth Pathway☐ Year Certified_____

   b. Name and location where internship served_____From:_____To:_____

   c. Name and location where residency served_____From:_____To:_____
   Please explain any breaks in chronology

   d. Residency specialty:_____

   e. Board Eligible? **Yes** ☐ **No** ☐ Expiration:_____

   f. Board certified **Yes** ☐ **No** ☐ Specialty:_____

PRACTICE PROFILE

8.a. Indicate the **PERCENTAGE** of time devoted to the following medical activities within the scope of your practice with **Carolinas HealthCare System**. ***(Total should equal 100%)***

____% Allergy	____% Infectious Diseases	____% Otorhinolaryngology
____% Anesthesiology	____% Intensive Care Medicine	____% Pathology
____% Broncho-Esophagology	____% Internal Medicine	____% Pediatrics
____% Cardiology	____% Laryngology	____% Perinatology
____% Cardiovascular Disease	____% Legal Medicine	____% Pharmacology-Clinical
____% Dermatology	____% Midwifery	____% Physical Medicine & Rehab
____% Diabetes	____% Neonatology	____% Psychiatry
____% Emergency Medicine	____% Neoplastic Diseases	____% Psychoanalysis
____% Endocrinology	____% Neurology	____% Psychosomatic Medicine
____% Family Practice	____% Nuclear Medicine	____% Public Health
____% Forensic Medicine	____% Nutrition	____% Pulmonary Diseases
____% Gastroenterology	____% Obstetrics/Pre-Natal Care	____% Radiology
____% Genetic Counseling	____% Occupational Medicine	____% Rheumatology
____% Geriatrics	____% Oncology	____% Rhinology
____% Gynecology	____% Ophthalmology	____% Urology
____% Hematology	____% Orthopedics	
____% Hypnosis	____% Otology	

8. b. Indicate the **PERCENTAGE** of time devoted to the following surgical activities within your scope of practice with **Carolinas Healthcare System**: ***(Total should equal 100%)***

SURGICAL ACTIVITIES

_____% Abdominal	_____% Head & Neck	_____% Pediatric
_____% Bariatrics	_____% Needle Biopsy	_____% Perinatology
_____% Cardiac	_____% Neonatal	_____% Plastic – Elective
_____% Cardiovascular	_____% Neurology	_____% Plastic-Otorhinolaryngology
_____% Colon & Rectal	_____% Obstetrics	_____% Thoracic
_____% Dermatology	_____% OB/GYN	_____% Trauma
_____% General	_____% Ophthalmology	_____% Urological
_____% Geriatrics	_____% Orthopaedic - spinal	_____% Vascular
_____% Gynecology	_____% Orthopaedic - no spinal	_____% Academic/Teaching
_____% Hand	_____% Otorhinolaryngology	

8. c. Select all non-hospital locations at which surgeries are performed:

(___) Office (___) Surgicenter (___)Other Non-Hospital Facility: specify_____

PRACTICE PROFILE

9. a. Please check the following medical techniques or procedures will perform within your scope of practice with **Carolinas Healthcare System**: **OR NONE OF THE BELOW** ☐

☐Abortions: which trimesters? _____ ☐Acupuncture – other than for anesthesia ☐ Adenoidectomies ☐Angioplasty ☐Arteriography ☐Angioplasty ☐Arthroscopy ☐Arteriography ☐Assistance in major surgery ☐On own patients ☐On patients of Others ☐Bariatric surgery – including gastric stapling / gastric bypass surgery ☐Blepharopigmentation ☐Biopsy (Endoscopic) ☐Blepharoplasty ☐Bronchoscopy ☐Breast Implants ☐Catheterization – arterial, cardiac or diagnostic ☐Chemobrasion or Dermabrasion ☐Cholangiopancreatography	☐Colonoscopy/Sigmoidoscopy ☐Cryosurgery – other than use on benign or lymphatic, sinus tracts and fistulae ☐D & C – non-abortive ☐ERCP (Endoscopic retrograde) ☐Fracture reductions - closed ☐Fracture reductions - open ☐Gastrointestinal Endoscopy ☐General/Spinal/Caudal anesthesia ☐Pulse oximetry ☐End tidal CO^2 analyzer ☐Gynecological Surgery (major) ☐Hemorrhoidectomies ☐Hernia Repair ☐High Risk Obstetrics ☐Laparoscopic surgery: specify_____ ☐Lasers – therapy / surgery ☐LASIK Surgery ☐Lithotripsy ☐Liposuction or suction assisted lipectomy ☐Lymphangiography ☐Lumbar punctures ☐Myelography ☐Needle Biopsy – including lung & prostate, **but not** including liver, kidney or bone marrow	☐Phenol facial peels ☐Phlebography ☐Pneumoencephalography ☐Pre-malignant dermatological lesions ☐Polypectomy ☐Prenatal practice ☐1st trimester ☐2nd trimester ☐3rd trimester ☐Radial/Laser Keratotomy ☐Radiation therapy ☐Radiopaque dye injection ☐Shock therapy ☐Silicone implants of any kind Specify: _____ ☐Sigmoidoscopies ☐Less than 60cm ☐Greater than 60cm ☐Skin Flap/Grafts ☐Tubal ligations ☐Any procedures disapproved by AMA or FDA* ☐Any experimental procedures* ***Please attach an explanation**

9. b. Please check the following diagnostic procedures you will perform within your scope of practice with **Carolinas Healthcare System**:

☐Catheterization, Intervention ☐Cataract surgery ☐Chelation therapy ☐Colonoscopies ☐Cryosurgery (other than external lesions) ☐Deliveries (annual number) Vaginal____ C-sections____ VBAC's____ Home Deliveries____ ☐Diagnostic embolization	☐Myelography ☐Needle biopsy ☐Nerve blocks (list sites) _____ _____ _____ ☐Pacemakers ☐Peritoneoscopy	☐Vasectomies ☐Weight Control-Therapy/Surgery ☐Bariatric Surgery ☐Medication-weight control ☐Other procedures(specify) _____ _____ ☐Other surgical techniques _____ _____

10. **Current Practice- General Questions**:
Any "yes" answers ***require a separate written explanation and supporting documentation***.

a. Do you provide medical information or advice, interpret films, prescribe medications or sell any products or services through any telecommunications, video, internet or other communication system where you are not face to face with a patient? **Yes**☐ **No**☐

b. Do you practice any experimental, investigational or other unconventional therapies including any alternative medicine practice? **Yes**☐ **No**☐

c. Do you participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved? **Yes**☐ **No**☐

d. Do you treat or review treatment of prison inmates? **Yes**☐ **No**☐
If yes, indicate percentage of practice _____%
If yes, are interactions with inmates via telemedicine? ☐Yes ☐ No

e. Do you treat professional athletes? **Yes**☐ **No**☐

f. Do you teach or supervise residents? **Yes**☐ **No**☐
If yes, is this exposure covered by another policy? ☐Yes ☐ No

g. Do you work in a hospital emergency room? **Yes**☐ **No**☐
If yes, please provide average hours worked per week_____

h. Are you providing professional services at any Nursing Home or Long Term Care facility? **Yes**☐ **No**☐
If yes, indicate percentage of practice_____%

i. Do you endorse any products or participate in any activity which offers professional advice to the public (i.e. newspaper columns, broadcasts, etc.)? **Yes**☐ **No**☐

j. Are you engaged in any moonlighting activities **Yes**☐ **No**☐
If yes, please provide insurance verification.

k. Has there been any change in your specialty in the past five years? **Yes**☐ **No**☐
If yes, describe:

11. a. How many continuing medical education credits did you achieve in the past year?_____

b. If you are not required to maintain continuing education credits as a prerequisite for licensing in your state, list all years._____

12. **<u>Current</u> Practice Locations: (please copy this page if additional space is needed for sections a-d)**

a. Office Locations:

Number and Street	City	State	Zip Code	County	% of practice
Number and Street	City	State	Zip Code	County	% of practice
Number and Street	City	State	Zip Code	County	% of practice

b. **Hospital Locations**: **(please copy this page if additional space is needed)**

Name	City	State	County	Description of Privileges	% of practice
Name	City	State	County	Description of Privileges	% of practice
Name	City	State	County	Description of Privileges	% of practice

c. Other Facility Locations: (i.e. Surgi-Centers, Emergi-Centers, Lab, Nursing Home, Correctional Facility, Clinic)

Name	Description	City	State	County	% of Practice
Name	Description	City	State	County	% of Practice

d. Previous Practice Locations: (List most recent first and explain any gaps in dates)

City	State	Description (office, hosp. etc.)	Specialty	Dates(from/to)
City	State	Description (office, hosp. etc.)	Specialty	Dates(from/to)
City	State	Description (office, hosp. etc.)	Specialty	Dates(from/to)
City	State	Description (office, hosp. etc.)	Specialty	Dates(from/to)

13. **License Information** :

_____ ☐Active ☐Inactive ☐Pending ☐Restricted ☐Revoked/Suspended
State License #

_____ ☐Active ☐Inactive ☐Pending ☐Restricted ☐Revoked/Suspended
State License #

_____ ☐Active ☐Inactive ☐Pending ☐Restricted ☐Revoked/Suspended
State License #

14. **Professional History:**
Any "yes" answers require a separate written explanation and supporting documentation.

a. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses? **Yes**☐ **No**☐

b. Have you ever been investigated by any state licensing board, narcotics board, DEA, or other governmental or regulatory agency? **Yes**☐ **No**☐

c. Have you ever been suspended, restricted, or put on probation by any governmental health program such as Medicare or Medicaid? **Yes**☐ **No**☐

d. Have any fee or professional relations complaints been registered against you with your medical associations, hospitals, or state licensing authorities? **Yes**☐ **No**☐

e. Have you been asked to participate in or have you volunteered to participate in an impaired physician program? (**If yes, please attach a copy of your recovery plan document**) **Yes**☐ **No**☐

f. Has any professional liability insurance carrier ever been declined, canceled, non-renewed, surcharged or conditioned? **Yes**☐ **No**☐
If yes, give details (use additional sheet if necessary)

g. Has any hospital ever denied, restricted, suspended or revoked your privileges; have you ever voluntarily surrendered your privileges; or has probation ever been invoked **Yes**☐ **No**☐

h. Has your narcotics or medical license ever been suspended, restricted, revoked or voluntarily surrendered or has probation been invoked? **Yes**☐ **No**☐

i. Have you ever been denied a medical license or been denied certification by a specialty board? **Yes**☐ **No**☐

PROFESSIONAL LIABILITY INSURANCE HISTORY

15. Current Professional Liability Insurance: ***If you are a current CMC Resident, please check here.*** ☐

	Insurance Carrier	Policy Period	Limit of Liability	Coverage Type	Retroactive Date	Deductible Amount	Tail Purchased
1.		From: To:		☐**Claims Made** ☐**Occurrence**			☐**Yes** ☐**No**
2.		From: To:		☐**Claims Made** ☐**Occurrence**			☐**Yes** ☐**No**
3.		From: To:		☐**Claims Made** ☐**Occurrence**			☐**Yes** ☐**No**
4.		From: To:		☐**Claims Made** ☐**Occurrence**			☐**Yes** ☐**No**

***Please attach your Certificate of Insurance for the past 5 years and return with your application.**

CLAIMS HISTORY

16. a. Are you now, or have you ever been involved, directly, or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services? **Yes**☐ **No**☐

*If yes, complete and attach a Claim Information Form for EACH such claim, potential claim, or suit.

17. a. Do you have knowledge of any claims, potential claims, or suits in which you may become? involved, including without limitation knowledge of any alleged injury arising out of the rendering or failure to render professional services, which may give rise to a claim? **Yes**☐ **No**☐

b. If yes, have these been reported to your present carrier **Yes**☐ **No**☐
*Complete and attach a Claim Information Form for EACH such claim, potential claim, or suit.

No Prior Acts Coverage

IMPORTANT: If you have previously been insured under a claims-made policy, please read.

A claims-made policy covers claims resulting from medical professional services provided or withheld on or after the retroactive date shown on the policy and first reported while the policy is in force. If you have been insured by a claims-made policy and did not purchase the Extended Reporting Endorsement from the insurer, you are NOT insured for your acts prior to the effective date of this policy. CHS has no obligation to defend or to pay claims resulting from medical professional services provided or withheld prior to the effective date of any policy issued upon this application.

If you have not had a discussion with your recruiter regarding an Extended Reporting Endorsement, please contact CHS Corporate Risk Management.

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE COVERAGE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE CHS OF SUCH CHANGES, AND CHS MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE COVERAGE.

SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR CHS TO COMPLETE THE COVERAGE, BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED, AND IT WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

ALL WRITTEN STATEMENTS AND MATERIALS FURNISHED TO CHS IN CONJUNCTION WITH THE APPLICATION ARE HEREBY INCORPORATED BY REFERENCE INTO THE APPLICATION AND MADE A PART HEREOF.

Signature of Applicant: _____

Time: _____

Date: _____

Previous Professional Liability Insurance Coverage and Claims History

I, the undersigned, have submitted an application for professional liability coverage to Carolinas HealthCare System. As part of the review process for coverage, I am required to submit documentation from my previous or present carrier related to my professional liability coverage and loss experience.

This form has been provided for your convenience in responding to the request for the information indicated below and to indicate that I, the undersigned, authorize the release of the requested information to Carolinas HealthCare System. If you choose to use your own form or letter, please be certain to include all the information requested. Unless your company guidelines require that this information be submitted directly to me as the insured, please return the information to:

Carolinas HealthCare System
Corporate Risk Management
P. O. Box 32861
Charlotte, NC 28232-2861

Phone: (704) 512-3410 ***FAX: (704) 512-3411***

Thank you for your assistance. Your prompt reply will assist me in completing the application process.

Applicant provides the following information:

Name (as it appears on Policy):_____
Print or Type

Signature Authorizing Release of Information:_____

Date of Signature: _____

Mailing Address: _____

_____

Provider should not complete the lower half of this page; continue to page 11

Insurance Carrier provides the following information:

Name of Professional Liability Carrier or Facility: _____

Coverage is: Claims Made ☐ or Occurrence ☐ **(Claims made will require purchase of Prior Acts Coverage)**

Dates of Coverage: _____ to _____

Retroactive Date (if applicable): _____

Are you aware of any closed or pending claims involving this physician? Yes☐ No☐
If yes, please provide additional details on a separate page.

**** Please provide a current certificate of insurance.**

PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY
CLAIM INFORMATION FORM

If no claims filed, check here ☐

1. Name of Applicant: _____
2. Patient's Name: _____
3. Date of incident from which claim resulted or is likely to result: _____
4. Date claim was made: _____
5. Allegations made against you: _____

_____

_____

_____

_____

6. Explain, in detail, the specifics of the incident which led or may lead to the claim: _____

_____

_____

_____

7. Present status or disposition of claim including amount reserved or amount of settlement or judgment, if any: _____
8. What insurance company is/was involved: _____
9. Name of other doctors, hospitals or institutions, if any, involved in the claim of suit: _____

_____

_____

The information provided on this form will be attached to and made part of your Application.

Date Completed _____ Signature of Applicant _____