***** ATTENTION – READ THIS PAGE *****

Complete this application in its entirety. Do not skip any of the questions.

Page 3 - #11 License Information:

If your N.C. license is in process, list "pending" under the license number and list what your percentage is expected to be once you begin working for our network.

Page 4 - #17-18 Professional Liability Insurance Information:

UNLESS you are a Carolinas Healthcare System (CHS) Resident, you must complete ALL of the information in this section or your application will not be processed further!

Page 5 – Claims History Questionnaire:

Answer all questions, sign, then date and time the form.

******Page 6 – Release Form:*******

Claims history verification is REQUIRED (whether claims exist or not). You must sign/complete page 6. You can return page 6 with the rest of the application and the underwriter will use the form to request your claims history. Or, you can make copies for each of your prior carriers and submit the form yourself to request the history is released to Corporate Risk (see form).

Request your claim history immediately since it will take the carriers time to return this to Corporate Risk Services.

Page 7 - Claim Information Form:

If no claims have been filed, check the box at top of page, sign and date. Otherwise, fill this section out completely if you have had claims filed that involve you.

Jennifer Lambert (T) 704-403-2276 (E) Jennifer.Lambert@carolinashealthcare.org

CAROLINAS HEALTHCARE SYSTEM

(Here in referred to as CHS)

PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY

APPLICATION FOR INDIVIDUAL PHYSICIANS

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: ***(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	____% Neonatology	____% Physical Medicine & Rehab
____% Diabetes	____% Neoplastic Diseases	____% Psychiatry
____% Emergency Medicine	____% Neurology	____% Psychoanalysis
____% Endocrinology	____% Nuclear Medicine	____% Psychosomatic Medicine
____% Family Practice	____% Nutrition	____% Public Health
____% Forensic Medicine	____% Obstetrics/Pre-Natal Care	____% Pulmonary Diseases
____% Gastroenterology	____% Occupational Medicine	____% Radiology
____% Genetic Counseling	____% Oncology	____% Rheumatology
____% Geriatrics	____% Ophthalmology	____% Rhinology
____% Gynecology	____% Orthopedics	____% Urology
____% Hematology	____% Otology	
____% Hypnosis		

8. b. Indicate the **PERCENTAGE** of time devoted to the following surgical activities: ***(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	

PRACTICE PROFILE

9. Please check the following medical techniques or procedures you perform: **OR NONE OF THE BELOW** ☐

☐ Abortions: which trimesters? ________________	☐ Hernia Repair
☐ Acupuncture – other than for anesthesia	☐ Lasers – used in therapy
☐ Angioplasty	☐ Laparoscopic surgery: specify_________________
☐ Arteriography	☐ Liposuction or suction assisted lipectomy
☐ Bariatric surgery – including gastric stapling / gastric bypass surgery	☐ Lumbar punctures
	☐ Myelography
☐ Catheterization – arterial, cardiac or diagnostic	☐ Needle Biopsy – including lung & prostate, **but not** including liver, kidney or bone marrow
☐ Chemobrasion or Dermabrasion	
☐ Colonoscopy/Sigmoidoscopy	☐ Pneumoencephalography
☐ Cryosurgery – other than use on benign or lymphatic, sinus tracts and fistulae	☐ Radiation therapy
	☐ Shock therapy
☐ pre-malignant dermatological lesions	☐ Silicone implants of any kind Specify: ________________________________
☐ D & C – non-abortive	
☐ ERCP (Endoscopic retrograde	☐ Any procedures disapproved by AMA or FDA*
☐ Cholangiopancreatography	☐ Any experimental procedures*
	*** Please attach an explanation**

PRACTICE PROFILE

10. Name all Facilities where you have practiced in the last five years. **Please explain any breaks in chronology.**

Name Of Facility or Practice	**During Years**

11. List **all** states where you are licensed to practice and license numbers

State	**License Number**	**% of Overall Practice In This State**
N.C.		

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

13. 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.________________________

14. Name and location of **all** hospitals where you hold staff or courtesy privileges

Name Of Facility	Location (City, State)	Type	% of Practice

15. Explain any yes answers below on a separate sheet.

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

b. 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**☐

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

d. 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**☐

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

16. Do you engage in any activities as an employee of the federal government **Yes**☐ **No**☐
If so, what percentage of your practice is devoted to this activity? **%**

PROFESSIONAL LIABILITY INSURANCE HISTORY

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

a. Present insurance carrier:____

b. Coverage type: Occurrence ☐ Claims Made ☐ **(If Claims made, attach copy of policy)**

c. Current Limits of Liability $ per claim $ _________aggregate $ __________

d. Policy Expiration Date _________________

18. Previous Professional Liability coverage - Past five years:

Carrier	Limit	Policy Term

CLAIMS HISTORY

19. 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**☐

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

20. 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.

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

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: ____

____

**** DO NOT COMPLETE THIS LOWER SECTION OF P.6 - You Insurance Carriers must complete this section ****

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 ____________________