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APPLICATION FOR LOCUM TENENS AND CONTRACT STAFFING ORGANIZATIONS PROFESSIONAL LIABILITY

(CLAIMS MADE BASIS)

APPLICANT'S INSTRUCTIONS:
1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.

1. APPLICANT INFORMATION

a. Name of Applicant Organization: _____

b. Principal business premise address: _____
(Street) (County)

_____
(City) (State) (Zip)

c. [ ] Corporation [ ] Limited Liability Corporation [ ] Partnership [ ] Other

d. Number of years under present ownership: _____

e. Number of employees: Full time _____ Part time _____ Total _____

f. Coverage is requested for: A. Locum Tenens [ ] B. Contract Staffing [ ]

g. Proposed Inception Date of Insurance: _____

h. Limits of Liability Requested: _____ (per claim) _____ (agg.) _____ (deductible)

i. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?..... [ ] Yes [ ] No

If Yes,

(i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?..... ..... [ ] Yes [ ] No

(ii) Provide the name and title of the Applicant's Privacy Officer._____

Our Business Associate Agreement is available. This is the only Business Associate Agreement we will recognize.

2. CLAIMS/HISTORY

a. Has the applicant or have any of the employed or contracted physicians:

(i) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? ..... [ ] Yes [ ] No

(ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?..... [ ] Yes [ ] No

(iii) Even been treated for alcoholism or drug addiction?..... [ ] Yes [ ] No

(iv) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?..... [ ] Yes [ ] No

(v) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance?..... [ ] Yes [ ] No

Please attach a detailed explanation for any Yes answers.

b. Has any claim or suit for alleged malpractice been brought against you? ..... [ ] Yes [ ] No

c. Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer? ..... [ ] Yes [ ] No

d. Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you? ..... [ ] Yes [ ] No

e. If you have responded Yes to Questions b, c or d above, please provide details on the attached claim history.

Claimant's Name	Institution City/State	Allegation	Type of Injury	Date of Loss	Status – 1. Incident, Claim, suit 2. Open/Closed	Amounts Paid to Date Indemnity/ Expense	Amounts Reserved to Date Indemnity/ Expense	Name of Insurance Carrier
1.					1. 2.			
2.					1. 2.			
3.					1. 2.			
4.					1. 2.			
5.					1. 2.			
6.					1. 2.			

f. List prior professional liability insurance carried for each of the past four years. [ ] None

Insurance Co.	Policy No.	Limits of Liability	Deductible	Premium	Inception Mo./Day/Yr	Expiration Mo./Day/Yr	Was this a Claims Made Policy Form? Yes No	Retro Date
							[ ] [ ]	
							[ ] [ ]	
							[ ] [ ]	
							[ ] [ ]	

3. RECRUITMENT AND RISK MANAGEMENT PROCEDURES

a. Has a formal professional liability risk management program been established for your operations? ..... [ ] Yes [ ] No [ ] Informal program only

Please provide documentation of the risk management program currently implemented.

b. Has a risk manager been designated to coordinate your risk management program?

[ ] Designated risk manager with a formal job description.

[ ] Designated risk manager without a formal job description.

[ ] No designated risk manager.

Please provide a copy of the risk manager's job description and C.V./Resume of the risk manager.

c. Has an administrator been designated to oversee recruiters and credentialers and the recruitment credentialing process?

[ ] Designated administrator with formal job description.

[ ] Designated administrator without formal job description.

[ ] No designated administrator.

d. Is there a designated physician medical director for the organization? [ ] Yes [ ] No
Please provide a copy of this doctor's curricula vitae.

e. How are the physician recruiters and credentialers organized? [ ] by specialty [ ] geographically
Please provide a copy of job description and C.V./Resume for the administrator.

f. Please describe the training and the experience level(s) of the physician recruiters and credentialer(s).

(i) _____

(ii) _____

(iii) _____

g. Are the recruiting and credentialing functions carried out by separate individuals within the organization? [ ] Yes [ ] No

h. How are physician recruiters and credentialers remunerated?

[ ] Salary [ ] Salary plus bonus/commission [ ] Per physician placement [ ] Other, please describe

i. Are there pre-established selection guidelines/protocol for recruiting physicians as candidates for the organization? [ ] Yes [ ] No
Please provide a copy of the selection guidelines/protocol.

j. Are quality of care data and information considered during physician evaluation?

[ ] Yes, considered and documented.

[ ] Yes, considered but not documented.

[ ] No, not considered

k. Are procedures developed for identifying, reporting and responding to unusual occurrences? [ ] Yes [ ] No

l. Does the organization's risk management process include clinical chart review?

[ ] Yes, formal review process with physician participation.

[ ] No chart review process.

m. Is there a centralized system for medical staff credentialing and privilege delineation?

[ ] Yes, centralized system with documentation.

[ ] No, each department or group responsible for own system.

[ ] No systems in place.

n. Are references listed by new applicants checked in writing? [ ] Yes [ ] No

o. Is the initial employment for a specified probationary period? [ ] Yes [ ] No

p. Is a practice profile completed for each facility into which physician(s) may be placed prior to assignment? [ ] Yes [ ] No

q. Is verbal communication between physicians and facilities encouraged prior to assignment? [ ] Yes [ ] No

r. Is there communication between the organization and hospitals, clinics or physician offices where physicians are placed regarding physician privileges?

[ ] Yes, a formal system of communication exists between hospitals and organization.

[ ] Yes, communication between hospital and organization, related to physician privileges, but no documentation.

[ ] No, not considered.

s. Are procedures developed to monitor the quality of patient care provided by the physicians placed in various settings, i.e., hospitals, physician offices, clinics? [ ] Yes [ ] No

t. Is there a formal process for claims review?

[ ] Formal claims review as part of risk management system.

[ ] Formal claims review system separate from risk management.

[ ] No claims review.

4. LOCUM TENENS

(Please complete this section if you operate as a Locum Tenens.)

a. EXPOSURE BASE List states in which locums intend to work, medical specialty and estimated number of days worked annually.

City & State where Services are Rendered	Medical Specialty	Minor Surgery? Yes No	Major Surgery? Yes No	Invasive Procedures? Yes No	Annual Locum Days
_____	_____	[ ] [ ]	[ ] [ ]	[ ] [ ]	_____
_____	_____	[ ] [ ]	[ ] [ ]	[ ] [ ]	_____
_____	_____	[ ] [ ]	[ ] [ ]	[ ] [ ]	_____
_____	_____	[ ] [ ]	[ ] [ ]	[ ] [ ]	_____

If additional space is needed, please attach separate sheet.

b. Are additional specialties to those scheduled above contemplated during the coming year? ..... [ ] Yes [ ] No

If Yes, please describe: _____

_____

c. Please provide information concerning "Physician Days," specialties and location by states for the past five years in the boxes below:

Fiscal Year	Total Number of Locum Tenens "Physician Days"*	Specialties (See Physician Classes 1A to 8 below)	States

* For all Physician specialties other than Emergency Medicine, a "Physician Day" is based upon an eight (8) hour shift, not including on-call time, worked within any twenty-four (24) hour period. A shift of zero (0) to four (4) hours shall be treated as a half day. Any hours in excess of four (4) hours up to eight (8) hours shall be considered a full day.

An Emergency Medicine "Physician Day" is based upon a twelve (12) hour shift, not including on-call time worked within any twenty-four (24) hour period. A shift of zero (0) to six (6) hours shall be treated as a half day. Any hours in excess of six (6) hours up to twelve (12) hours shall be considered a full day.

d. Schedule of Medical Specialties

Physician Classes 1A to 8		**No. Full Time**	**No. Part Time**
1A	Allergists, Dermatologist, Pathologists, Psychiatrists, Public Health		
1	Physicians - no surgery, no invasive procedures, no obstetrical procedures		
2	Physicians - minor surgery, invasive procedures, including: Nephrology, Neoplastic Oncology, Geriatrics, Gastroenterology, Oral Surgeons		
3	Family or General Practice - normal deliveries, Urologists, Reproductive Endocrinology, including fertility specialists, Ophthalmologists, Neonatology		
4	Emergency Medicine - no major surgery, Otorhinolaryngology (non-elective cosmetic surgery)		
5A	Anesthesiologist		
5	Surgery - including General, Emergency, Plastics and Gynecologists		
6	Surgery - including cardiac and cardiovascular surgery and orthopedics without spinals, Thoracic surgeons		
7	Obstetrics, OB/GYN, orthopedics with spinals		
8	Surgery - Neurological		
Other, e.g. Nurse Practitioners, Physician Assistants, Therapists, Pharmacists			

5. CONTRACT STAFFING (Please complete this section if you operate as a contract staffing organization.)

a. Exposure Base:List below names and addresses of all locations where emergency and other outpatient services are rendered. For Medical Specialty, please refer to "Schedule of Medical Specialties" above.

Location Name of Facility, City, State	Type of Facility, e.g. Hospital, clinic, urgent care, trauma	Estimated Annual Number of Emergency Room/Dept Visits	Estimated Annual Number of Clinic Visits	Medical Specialty	Other Operations/ Services Rendered	Retroactive Date of Location to be covered

If additional space is needed, please attach separate sheet.

b. Is the adding of additional sites contemplated during the coming year?..... [ ] Yes [ ] No
If "Yes", please describe: _____

_____

c. Please provide the following information for the past five years:

Fiscal Year	Total No. of ER Visits	Total No. of Clinic Visits
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

d. Schedule of Physicians

Name	Hired Date	Terminated Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

WARRANTY: It is warranted to the underwriting manager, Company and/or affiliates thereof, that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I/We hereby authorized the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

PLEASE REVIEW THE POLICY CAREFULLY. Except to such extent as may be otherwise in the policy, the coverage for which application is being made is limited to liability for only THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD.

Name of Applicant	Title (Officer, partner, etc.)
Signature of Applicant	Date

*SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE INSURER OR THE UNDERWRITING MANAGER TO COMPLETE THE INSURANCE. Application MUST be currently signed and dated to be considered for quotation.