

THE PHYSICIANS TRUST

P.O. Box 40318 · Baton Rouge, LA 70835-0318
4646 Sherwood Common Blvd. · Baton Rouge, LA 70816
Telephone (225) 368-3888 · Fax (225) 272-1823

Physicians and Surgeons Professional Liability Renewal Application

Named Participant: _____
Address: _____
City: _____
Corporate Coverage: _____
Specialty: _____
Current Limits: _____

Certificate Number: _____
Retroactive Date: _____
Expiration Date: _____
License Number: _____
Class: _____
Date of Birth: _____

**IMPORTANT: PLEASE PRINT OR TYPE AND ANSWER ALL QUESTIONS
(RETAIN A COPY WITH YOUR COVERAGE DOCUMENTS)**

THIS IS A REQUIRED RENEWAL DOCUMENT WHICH MUST BE RETURNED NO LATER THAN _____.

Information shown above is correct. Yes No
If no, please indicate changes above.

1. Current medical and/or DEA license status: Active Suspended Probationary Revoked
License # _____ DEA # _____
If other than active, please explain on supplemental form.

2. Have there been any changes in your practice, including procedures performed or **hours worked**? Yes No
If yes, please explain on supplemental form.

3. Where do you maintain privileges? Please list _____

4. Has any clinic, hospital, or health care facility suspended, restricted, or revoked your privileges? Yes No
If yes, please explain on supplemental form.

5. Has any claim or suit been brought against you in the past year, or are you aware of any circumstances that might reasonably lead to such a claim or suit of which we have not been notified? Yes No
If yes, please explain on supplemental form.

6. Has your Medicare or Medicaid license ever been revoked, suspended, placed on probation or voluntarily surrendered? Yes No

7. Have you have been diagnosed with or are in a treatment for any disease either mental, physical or emotional, including but not limited to, chemical or alcohol dependency or HIV/AIDS, which may affect your ability to render services as a healthcare provider? Yes No
If yes, please explain on supplemental form.

8. I elect to increase my coverage limits to \$1,000,000/\$3,000,000 per quote provided. Yes No

9. Do you employ or supervise any advanced practice professionals (i.e. physicians, midwives, nurse anesthetists, physician extenders). These employees must complete a separate application. Yes No
If yes, please explain on supplemental form.

MEDICAL PROCEDURES – CHECK ALL PROCEDURES THAT YOU PERFORM:

IF YOU DO NOT PERFORM ANY OF THE PROCEDURES LISTED BELOW, PLEASE CHECK HERE

OFFICE	HOSPITAL	OTHER	PROCEDURE
			Abortion (Do you perform elective abortions of uncomplicated viable pregnancies?) Yes <input type="checkbox"/> No <input type="checkbox"/> (Which trimester? _____) (#per year _____)
			Acupuncture
			Amniocentesis
			Angiography (Cardiac/Peripheral) Circle those that apply
			Angioplasty (Cardiac/Peripheral) Circle those that apply
			Appendectomy
			Arthroscopic Procedures (Attach summary of training)
			Blepharoplasty
			Botox Injections (Cosmetic/Physiatry) Circle those that apply
			Breast Surgery (Do you perform implants?) Yes <input type="checkbox"/> No <input type="checkbox"/> (Number per year _____)
			Bronchoscopy
			Cardiac Catheterization
			Chelation Therapy (Lead Removal/Arteriosclerotic Heart Disease) Circle those that apply
			Circumcisions (other than newborns)
			Cryosurgery (other than use on benign, malignant or pre-malignant dermatological lesions)
			Colonoscopy (with anesthesia/parenteral sedation/conscious sedation/without conscious sedation) Circle those that apply
			Cosmetic Plastic Surgery (Elective/Traumatic) Circle those that apply
			Dermabrasion (Indicate % of time devoted to this procedure) _____ %
			D&C's
			Electroconvulsive Therapy
			ERCP (Endoscopic Retrograde Cholangioancreatography)
			GI Endoscopy (with anesthesia/parental sedation/conscious sedation) Circle those that apply
			Hair Transplants
			- Scalp Excision/Transplants Yes <input type="checkbox"/> No <input type="checkbox"/> - Plug Technique/Mingraph Yes <input type="checkbox"/> No <input type="checkbox"/>
			Hemodialysis
			Kyphoplasty
			Laparoscopic Procedure(s) - (Diagnostic/Therapeutic) Circle those that apply
			Liposuction
			Lithotripsy
			Lumbar Puncture
			Lymphangiography
			Myelography
			Needle Biopsy (including lung, prostate, liver & kidney)
			Obstetrical Deliveries
			- Caesarian Sections Per Year # _____ Vaginal Per Year # _____
			Occipital Nerve Blocks
			Permanent Pacemaker Insertions
			Phenol Facial Peels
			Placement of access lines for dialysis, chemotherapy & CVP
			Pneumoencephalography
			Sigmoidoscopy (with anesthesia/parental sedation/ conscious sedation/without conscious sedation) Circle those that apply
			Swan-Ganz Catherization (Annual number performed # _____)
			Temporary Pacemaker Insertions (Annual number performed # _____)
			Tonsillectomy
			TURPS (Transurethral Resection of Prostate)
			Vasectomies
			Vertebroplasty
			Vision Correction Surgery: Type (s) Performed _____
			Weight Loss Surgical Procedures (Annual number performed # _____) (Specify Type _____)

ARE YOU ASSISTING IN MAJOR SURGERY ON OWN PATIENTS? Yes No

ASSISTING IN MAJOR SURGERY ON OTHER THAN OWN PATIENTS? Yes No

ARE THERE ANY PROCEDURE NOT USUAL OR CUSTOMARY TO YOUR SPECIALTY? (Please explain on Supplemental Form) Yes No

ANY PROCEDURE OR TREATMENT USING OFF LABEL PRODUCTS NOT APPROVED BY THE FDA? (Please explain on Supplemental Form) Yes No

ADDITIONAL PROCEDURES THAT YOU PERFORM OR ANY PROCEDURE NOT LISTED ABOVE? (Please list on Supplemental Form) Yes No

FOLLOW YOUR OWN PATIENTS POST-OPERATIVELY? Yes No

NOTICE AND DECLARATION

In the event this application is accepted by the Trust, and a Certificate of Coverage is issued, Applicant hereby ratifies and confirms the appointment by the Fund's Board of Trustees of HSLI as Service Agent, and acknowledges that the Trust will designate defense counsel for handling the defense of claims for the Trust; and agrees to be bound by the terms and provisions of the Trust Agreement.

The Applicant expressly represents and warrants that the information provided in this application (and attachments) and any subsequent applications are true and correct and that no material facts have been suppressed or misstated. Applicant specifically acknowledges that the Trust has relied on statements contained in this application to issue coverage and establish the amount to charge for the contract, particularly as to claims made and prior acts or retro coverage as to disclosing all incidents occurring in the last two (2) years where Applicant knows or has reason to believe a claim may be made in the next two years. Applicant also acknowledges that any failure to disclose material facts affecting coverage, losses and premiums, including incidents that have occurred at the time of this application or subsequent to the completion of the application but prior to the effective date of coverage, but not made until after coverage is instituted may constitute a material misrepresentation or fraud causing the denial of coverage or the rescinding or voiding of the coverage contract.

Applicant understands the submission of this application does not bind the Trust to issue or Applicant or institution to purchase this coverage. By signing below, Applicant grants permission (1) to the Trust to contact third parties and (2) for third parties to release to the Trust information which relates to the issuance and continuation of this coverage. Applicant also understands that knowingly providing false, incomplete or misleading information to the Trust for the purpose of defrauding the Trust may constitute a crime punishable by imprisonment, fines, and/or a denial of coverage.

Applicant acknowledges that, in the event this application is accepted by the Trust and a Certificate of Coverage is issued, Applicant and/or institution will remain responsible for any deductible amounts owed even after termination of the coverage, and as a duly authorized representative of Applicant and/or institution, promises on behalf of Applicant and/or institution, to pay all deductible amounts owed under the coverage agreement and should any amounts owed to the Trust under the coverage agreement be turned over to an attorney for collection, that Applicant and/or institution shall be liable for attorney's fees and all costs of collection.

Applicant hereby certifies that they have signed this application with the specific authority of the Board or governing body of the institution. By placing their name on this application, it constitutes an electronic signature which legally binds him/her and the institution to the accuracy of the information inserted within as if they had actually signed the original application.

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Signature of Individual and Authorized Partner or Corporate Representative

Date

BY MY SIGNATURE, I AM AUTHORIZING A REPRESENTATIVE OF THE PHYSICIANS TRUST TO OBTAIN MY MEDICAL PROFESSIONAL LIABILITY CLAIMS' HISTORY FROM THE LOUISIANA PATIENT'S COMPENSATION FUND.

