

THE PHYSICIANS TRUST

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Physicians and Surgeons Professional Liability Application—*Locum Tenens*

Any physician who takes over the practice of another physician on a temporary basis must complete a *locum tenens* application. Policy limits of the The Physicians Trust insured are shared with the *locum tenens* physician. Please type or print, answer all questions completely.

Personal Information			
Name of Locum Tenens		Name of The Physicians Trust Insured	
Office Address (include city, state, zip)			Years at this location
Billing Address (include city, state, zip)			Other Locations (if any)
Home Address (include city, state, zip)			
Medical Group Name (if any)	Social Security No.	Date of Birth	Parish Medical Society
Office Phone	Fax Number	Home Phone	E-mail Address

Desired Coverage Period (period you will be temporarily serving in the PT insured's place) _____

Underwriting and Rating Information

1.a. Do you have a current license to practice medicine in LA? Yes No LA License No.: _____

1.b. State and Federal Narcotics License Numbers: _____

1.c. Do you have restrictions? (if yes, explain) _____ Yes No

2. List other states where licensed and license #s: _____

3. Undergraduate School, Location	Degree	Year
Medical School, Location	Degree	Year
Postgraduate Training, Location	Specialty	Year(s)
Served Internship at (PG I)		Year(s)
Served Residency at (PG II - ?)		Year(s)

4. Are you certified by an approved specialty board? (If yes, which?) _____ Yes No

5. What is your medical specialty? _____
 NOTE: If your medical specialty is not the same as the PT insured's specialty, please describe in the remarks section the duties you will be performing while substituting for the PT insured.

6. Will you perform or assist in surgery? Yes No If yes, will this be confined to the PT insured's patients? Yes No

7. Medical or Surgical Procedures (Please indicate whether you perform any of the following):

- Anesthesia** General Spinal Epidural
- Assisting in major surgical procedures**
- Minor Surgery & Procedures**—Includes operations and procedures not considered to be major surgery, involving primary treatment of limited abnormalities, injuries, and infections of the skin and superficial tissue, usually using local anesthesia and predominantly performed on an outpatient basis. It includes but is not limited to the following list. Check all applicable:
- | | |
|--|--|
| <input type="checkbox"/> No procedures—only consulting or diagnostic | <input type="checkbox"/> Cryosurgery |
| <input type="checkbox"/> Incisions of boils and superficial abscesses | <input type="checkbox"/> On benign dermatological lesions |
| <input type="checkbox"/> Suturing of skin and superficial fascia | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Acupuncture—other than acupuncture anesthesia | <input type="checkbox"/> Dermabrasion |
| <input type="checkbox"/> Angiography | <input type="checkbox"/> Diagnostic sonography |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Discograms |
| <input type="checkbox"/> Coronary | <input type="checkbox"/> Electroshock therapy (psychiatric) |
| <input type="checkbox"/> Peripheral | <input type="checkbox"/> Fiberoptic bronchoscopy |
| <input type="checkbox"/> Bone fractures: closed treatment | <input type="checkbox"/> Hair transplant |
| <input type="checkbox"/> Cancer chemotherapy | <input type="checkbox"/> Interventional endoscopy—specify type: _____ |
| <input type="checkbox"/> Catheterization | <input type="checkbox"/> Laser therapy—specify type: _____ |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Liposuction |
| <input type="checkbox"/> Transarterial | <input type="checkbox"/> Myelography |
| <input type="checkbox"/> Occasional insertion of pulmonary wedge, recording catheters, or temporary pacemakers | <input type="checkbox"/> Needle biopsy |
| <input type="checkbox"/> Transvenous | <input type="checkbox"/> Lung, liver, kidney, or prostate |
| <input type="checkbox"/> Umbilical cord catheterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen (other than emergency or for transport) | <input type="checkbox"/> Bone marrow |
| <input type="checkbox"/> Cervical conization—specify type: _____ | <input type="checkbox"/> Other |
| <input type="checkbox"/> Circumcision | <input type="checkbox"/> Nerve blocks, therapeutic—specify type: _____ |
| <input type="checkbox"/> Colonoscopy | <input type="checkbox"/> Pneumatic or mechanical esophageal dilation (not with bougie or olive) |
| <input type="checkbox"/> Cosmetic injections—specify type: _____ | <input type="checkbox"/> Radiopaque contrast material injections into blood vessels, lymphatic, sinus tracts, and fistulae |
| <input type="checkbox"/> Cosmetic skin flaps and skin grafts: _____ | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Major Surgery —Includes operation procedures in or upon any body cavity including cranium, thorax, abdomen, pelvis; any other operations or procedures which, because of the condition of the patient or the length or circumstances of the operation, present a distinct hazard to life. It also includes but is not limited to the following list. Check all applicable: | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Amputations | |
| <input type="checkbox"/> Bone fractures | <input type="checkbox"/> Operative treatment <input type="checkbox"/> Closed manipulation-general or regional anesthesia |
| <input type="checkbox"/> Fertility or reproductive surgery | |
| <input type="checkbox"/> Gynecological procedures | <input type="checkbox"/> Dilation and currettements other than emergency |
| <input type="checkbox"/> Laparoscopic Cholecystectomy | |
| <input type="checkbox"/> Laparoscopy | <input type="checkbox"/> Diagnostic <input type="checkbox"/> Sterilization <input type="checkbox"/> Therapeutic |
| <input type="checkbox"/> Liposuction | |
| <input type="checkbox"/> Minimal invasive endoscopic surgery—specify type: _____ | |
| <input type="checkbox"/> Obesity surgery—specify type: _____ | |

- Obstetrical procedures
 Abortions
 Cesarean sections
 Forceps delivery other than outlet forceps

 Elective

 Home delivery

 Therapeutic

 Vaginal delivery

 Other _____
- Penile implants
 Percutaneous disc surgery
 Plastic surgery
 Cosmetic—specify type: _____
 Breast augmentation

 Reconstructive—specify type: _____

 Facial—specify type: _____
- Radial keratotomy
 Spine surgery
 Primary
 Reoperative

 Cervical

 Cervical

 Thoracic

 Thoracic

 Lumbar

 Lumbar

 Spinal instrumentation

 Spinal instrumentation
- Tonsillectomies and/or adenoidectomies
 Other—specify type: _____

NOTE: If you answer yes to any of the following questions, please give detailed information in the remarks section of this application. (Attach additional sheets if necessary.)

8. Has any hospital or medical staff ever restricted or revoked your privileges or invoked probation? Yes No
9. Has your license to practice medicine or narcotics license ever been revoked, voluntarily suspended, or subjected to probation or are you aware of any circumstances that might lead to such? Yes No
10. Has your membership in any medical association or society ever been refused, suspended, revoked, voluntarily surrendered or been censured? Yes No
11. Have you been treated for alcoholism, narcotic addiction or mental illness? Yes No
12. Have you now or have you ever had a chronic illness or physical defect that impairs or could tend to impair your ability to practice medicine? Yes No
13. Have you been convicted of a crime (other than a motor vehicle violation)? Yes No
14. Have fee complaints or professional relations complaints been registered against you with your medical society/association or state licensing authority within the past five years? Yes No
15. Has your professional liability insurance ever been cancelled, non-renewed, restricted or surcharged, or has your professional liability insurer ever asked you not to renew your policy? Yes No
16. Has any insurance carrier ever declined professional liability insurance to you? Yes No
17. Has any claim or suit for alleged malpractice ever been brought against you? Yes No
18. Are you aware of any circumstances that might reasonably lead to such a claim or suit? Yes No

NOTE: If you answered yes to question 18, please provide the following information to complete and expedite our underwriting review:

- (1) a copy of the complete hospital chart, your office records, and a complete copy of all medical records (hospital, ambulatory care, office, etc.) pertinent to the claim;
- (2) a copy of the petition filed against you, and/or any judgment or settlement if applicable; and
- (3) a full typewritten narrative, in your own words, of each situation, including a statement of the facts at issue (include names, dates, places, your diagnosis, and treatment of the case).

Please be as thorough as possible in order for the underwriter to give your application a prompt review.

19. Name of current professional liability insurance carrier including expiration date, policy number, and limits:

20. List names of all professional liability insurance carriers that you have been insured with for the last 10 years and dates of coverage: _____

21. How many times have you changed your place of practice in the last 10 years, and what were the reasons for the changes?

Question No.	Remarks

Sign and date application in the space below.

I hereby declare that all statements and answers herein are full, complete, and true to the best of my knowledge and belief and that no material circumstance or information concerning the subject matter of the questions asked has been withheld or omitted.

I authorize any professional societies, prior or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions or persons that may have any record or knowledge concerning any of the statements and answers made herein to release such information to HSLI/The PT upon its request. I authorize the use of a copy of this authorization in place of the original.

Signing this application does not bind the company to renew a policy of insurance. However, it is agreed that this form shall be the basis of the policy.

 Applicant Signature

 Date