



## SOCIAL SERVICE ORGANIZATIONS PHYSICIAN INFORMATION SHEET

DATE:	APPLICANT
PRODUCER	
COMPANY General Insurance Company of America	
<b>BLACK/WHITE ASSOC. / INSURANCE BROKERS</b> 1999 Harrison St., Suite 1230, Oakland, CA 94612 Phone: (510) 465-5773, Fax: (510) 465-2226	

Name of Physician \_\_\_\_\_

Name of Clinic / Care Center \_\_\_\_\_

Medical Specialty \_\_\_\_\_

Are you board certified in your specialty?  Yes  No    If no, are you eligible?  Yes  No

License Number(s) \_\_\_\_\_ Permanent or Temporary? \_\_\_\_\_

Describe the professional services you provide on behalf of the Clinic / Care Center: \_\_\_\_\_

How many hours per week do you work on behalf of the Clinic / Care Center? \_\_\_\_\_

How many weeks per year do you work on behalf of the Clinic / Care Center? \_\_\_\_\_

Do you perform surgery on behalf of the Clinic / Care Center?  Yes  No    If yes, please explain.

Do you administer any anesthesia on behalf of the Clinic / Care Center?  Yes  No    If yes, please explain.

Do you now, or intend to in the future, supervise or perform any of the following procedures on behalf of the Clinic / Care Center?

	# / Year		# / Year
Angiography	<input type="checkbox"/> Yes _____	Radiotherapy	<input type="checkbox"/> Yes _____
Pneumoencephalography	<input type="checkbox"/> Yes _____	Isotope Therapy	<input type="checkbox"/> Yes _____
Dermabrasion / Chemabrasion	<input type="checkbox"/> Yes _____	Chemotherapy	<input type="checkbox"/> Yes _____
Amniocentesis	<input type="checkbox"/> Yes _____	Catheterization	<input type="checkbox"/> Yes _____
Sterilization Operations	<input type="checkbox"/> Yes _____	Invasive Diagnostic Tests	<input type="checkbox"/> Yes _____
Electro Convulsive / Shock Therapy	<input type="checkbox"/> Yes _____	Obstetrics (including Pre- & Postnatal Care)	<input type="checkbox"/> Yes _____
Myelography	<input type="checkbox"/> Yes _____	Abortions	<input type="checkbox"/> Yes _____
Gastric Bubble	<input type="checkbox"/> Yes _____	AIDS Treatment	<input type="checkbox"/> Yes _____
Neonatal Care	<input type="checkbox"/> Yes _____	Mammography	<input type="checkbox"/> Yes _____
Peritoneoscopy	<input type="checkbox"/> Yes _____		

Have you ever had a malpractice claim or suit filed against you?  Yes  No  
If yes, explain on reverse side.

Have you ever had your license revoked, suspended or restricted?  Yes  No  
If yes, explain on reverse side.

Have you ever been:  
The subject of an investigatory or disciplinary proceeding or reprimand?  Yes  No

Convicted for an act committed in violation of any law or ordinance other than traffic offenses?  Yes  No

Treated for alcoholism or drug addiction?  Yes  No

Please provide the following information regarding your professional liability coverage:

Carrier \_\_\_\_\_

Effective Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

Policy Limits \$ \_\_\_\_\_ each claim \$ \_\_\_\_\_ aggregate

Retroactive date \_\_\_\_\_

Annual premium \$ \_\_\_\_\_

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_