



SOCIAL SERVICE ORGANIZATIONS PHYSICIAN INFORMATION SHEET

DATE:	APPLICANT
PRODUCER	
COMPANY General Insurance Company of America	
BLACK/WHITE ASSOC. / INSURANCE BROKERS 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 _____



SOCIAL SERVICE ORGANIZATIONS

PHYSICIANS PROFESSIONAL LIABILITY APPLICATION

CLAIMS-MADE OCCURRENCE

DATE:	SOCIAL SERVICE ORGANIZATION
PRODUCER	

COMPANY General Insurance Company of America

BLACK/WHITE ASSOC. / INSURANCE BROKERS
1999 Harrison St., Suite 1230, Oakland, CA 94612
Phone: (510) 465-5773, Fax: (510) 465-2226

1. Name of Individual Practitioner:	Degree: <input type="checkbox"/> MD <input type="checkbox"/> D.O. <input type="checkbox"/> Other:
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Social Security #:	Date of Birth:	Date Practice Began:
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2. Principal Location:

3. What is your relationship to the Social Service Organization: Owner Volunteer Employee
 Independent Contractor Other:

4. List below all professional schools attended:

NAME	CITY	STATE	YRS. ATTENDED	DATE GRADUATED	DEGREE

5. List below the states where you are licensed:

STATE	DATE LICENSE OBTAINED	LICENSE NUMBER	
			<input type="checkbox"/> Active <input type="checkbox"/> Inactive
			<input type="checkbox"/> Active <input type="checkbox"/> Inactive
			<input type="checkbox"/> Active <input type="checkbox"/> Inactive

6. If you are a foreign medical school graduate, are you certified by the Educational Commission for Medical School Graduates? Yes No

7. Was your Post Graduate Education an: Internship Residency Other (describe)

8. Where was your Post Graduate Education completed? Please list below:

HOSPITAL/FACILITY	CITY	STATE	# YRS. COMPLETED	COMPLETION DATE

9. List your Medical/Surgical Specialty: _____

10. Is your practice limited to this specialty? Yes No

11. For my specialty, I am: Board Eligible American Board Certified
 Dates of Certification: _____

12. Responsibilities for the Social Service Organization, including any administration or prescription of medication: _____

13. Have you ever prescribed Fen-Phen or Fen-Phen/Redux to anyone? Yes No
 If Yes, for how many patients did you prescribe it? _____
 Have you been notified of any suits? Yes No
 If Yes, give details: _____

14. List the name and date of any risk management seminar or program you have participated in over the last 2 years. _____

15. How many continuing education credits have you received in the past year? _____

16. What type of informed consent do you use? Oral Written None
 If Oral, is chart noted, dated and initialed by patient? Yes No

17. Follow-up care and/or other instruction given to the patient are:
 Oral Preprinted Handwritten Hospital Form

18. Indicate the level of anesthesia you use when providing services for or on behalf of the Social Service Organization:
 Local or Oral IV Conscious Sedation General Anesthesia

19. Indicate the

- a. Number of hours per week practiced for or on behalf of the Social Service Organization: _____
- b. Number of patients treated by you at the Social Service Organization:
 Weekly: _____ Annually: _____
- c. Number of hours per week you practice in an Emergency Room None _____
- d. Number of hours per week you engage in private practice: _____
- e. Number of formal or informal consultations with other physicians in the past year:
 _____ Requested by other physicians _____ Provided by other physicians

20. Do you assist in surgery on:
 Your own patients? Yes No
 On patients of others? Yes No

- 21.** Check the procedures you perform on behalf of the Social Service Organization or for its patients:
- | | | |
|---|--|---|
| <input type="checkbox"/> Arteriography | <input type="checkbox"/> Dermabrasion/Chemabrasion | <input type="checkbox"/> Hypnosis |
| <input type="checkbox"/> Lymphangiography | <input type="checkbox"/> Needle biopsies | <input type="checkbox"/> Radial or hexagonal keratotomy |
| <input type="checkbox"/> Myelography | <input type="checkbox"/> * Mohs micrographic surgery | <input type="checkbox"/> Reconstructive / Cosmetic Surgery |
| <input type="checkbox"/> Pneumoencephalography | <input type="checkbox"/> * Acupuncture anesthesia | <input type="checkbox"/> Hair Transplants / suturing / hairpieces |
| <input type="checkbox"/> Interventional radiology | <input type="checkbox"/> Varicose Vein Stripping | <input type="checkbox"/> Open or closed reduction of fractures |

- | | | |
|--|---|--|
| <input type="checkbox"/> Percutaneous transluminal angioplasty | <input type="checkbox"/> * Prenatal care and deliveries | <input type="checkbox"/> Experimental research |
| <input type="checkbox"/> Percutaneous transluminal embolization | <input type="checkbox"/> Dilation and curettage | <input type="checkbox"/> Experimental therapy in human patients |
| <input type="checkbox"/> Radiation therapy—deep (includes radium implants) | <input type="checkbox"/> Non spontaneous, induced abortions | <input type="checkbox"/> Surgery other than incisions of boils & superficial abscesses or suturing skin & superficial fascia |
| <input type="checkbox"/> Electroshock therapy | <input type="checkbox"/> * Other Surgery | |

* Describe on separate sheet of paper

22. Has any governmental or licensing agency ever investigated you, or suspended, revoked, placed on probation, or taken any other action against either your narcotics license or your license(s) to practice medicine? <i>If Yes, please give details on a separate sheet.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No				
23. Has any hospital or other institution reduced, revoked, restricted or suspended your privileges ? <i>If Yes, give details on a separate sheet.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No				
24. Have you ever been the subject of a mediation, peer review, investigation, disciplinary proceeding or reprimand by an administrative or governmental agency, professional association or hospital? <i>If Yes, please give details on a separate sheet:</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Do you have or have you had any physical disability or injury, personal health problems, including alcoholism, narcotics addiction or mental illness which affected your ability to practice medicine? <i>If Yes, please give details on a separate sheet.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No				
26. Have you or any of your employees ever been convicted of a crime (other than a motor vehicle citation)? <i>If Yes, please give details on a separate sheet.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No				
27. Has any medical practitioner, Medicare/Medicaid patient or insurance plan ever filed a complaint against you with any medical society or organization? <i>If Yes, please give complete details on a separate sheet.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No				
(In the State of Missouri, the following question does not apply)					
28. Has any insurance carrier ever declined, canceled, rescinded or modified coverage or refused to renew your professional liability coverage? <i>If Yes, give details on a separate sheet.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No				
29. Has any claim or suit been brought against you on account of alleged malpractice, error or mistake in the past five years? <i>If Yes, give details for each incident on a separate sheet.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No				
30. Do you have knowledge of any medical incident or activity which might give rise to a claim against you that you haven't reported to your professional liability insurance company?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
31. Is your current professional liability insurance policy an: <input type="checkbox"/> Individual Policy <input type="checkbox"/> Institution Policy					
32. Does your current policy provide coverage for professional employees?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
33. Please provide the name(s) of your professional liability carrier(s) and coverage date(s), retroactive date(s), limits and premium(s) for the last three years.					
Insurance Company	Coverage Date	Retroactive Date	Policy Limits	Premium	Claims Made Form?
					<input type="checkbox"/> Yes
					<input type="checkbox"/> Yes
					<input type="checkbox"/> Yes

Fraud Warning

Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and (NY: substantial) civil penalties. In Maine and Virginia, insurance benefits may also be denied.

I understand that in order to underwrite professional liability insurance, the Company must have access to information concerning my personal and professional life. I hereby authorize and direct any medical society, medical professional, hospital, residency program, insurance company, underwriter, insurance agent or other entity to furnish any information concerning me or my medical practice which the Company may request. I understand that any policy issued will rely on the truth of the statements and representations I have made herein and that misrepresentations that are fraudulent, or such that the Company would not have issued the policy if the true facts had been known, may result in a denial of coverage for any claim which may be made under this insurance.

Applicant's Signature

Date

COMPLETION OF THIS FORM NEITHER BINDS COVERAGE NOR GUARANTEES
A POLICY WILL BE ISSUED.