QUESTIONNAIRE FOUR
(Applicant must complete all applicable Questionnaires)

PHYSICIAN'S PROFESSIONAL LIABILITY QUESTIONNAIRE

(Attachment to NIF Social Services Agencies Application)
Applicant must complete a separate Questionnaire for each Physician desiring coverage.)

Name of Applicant:_____

☐ CLAIMS-MADE ☐ OCCURRENCE
If claims made, please include the retro date _____

Name of Individual Practitioner: _____
Degree: ☐ MD ☐D.O. ☐Other:_____

Social Security #: _____ Date of Birth: _____ Date Practice Began: _____

Principal Location:_____

What is your relationship to the Applicant?'
☐Owner ☐Volunteer ☐Employee ☐Independent Contractor ☐Other:_____

List below all professional schools attended:

NAME	CITY	STATE	YRS. ATTENDED	DATE GRADUATED	DEGREE
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

List below the states where you are licensed:

STATE	DATE	LICENSE OBTAINED	LICENSE NUMBER	
_____	_____	_____	_____	☐Active ☐ Inactive
_____	_____	_____	_____	☐Active ☐ Inactive
_____	_____	_____	_____	☐Active ☐ Inactive

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

Was your Post Graduate Education an:
☐Internship ☐Residency ☐Other (describe) _____

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

HOSPITAL/FACILITY	CITY	STATE	# YRS. COMPLETED	COMPLETION DATE
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List your Medical/Surgical Specialty or Specialties: _____

Is your practice limited to these specialty/specialties? ☐Yes ☐No

For my specialty(ies), I am: ☐ Board Eligible ☐American Board Certified
Dates of Certification: _____

Position and duties performed for the Applicant:

_____
_____
_____

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:

_____
_____

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

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

What type of informed consent do you use? ☐Oral ☐Written ☐None

If Oral, is chart noted, dated and initialed by patient? ☐Yes ☐No

Follow-up care and/or other instruction given to the Client is:
☐Oral ☐Preprinted ☐Handwritten ☐Hospital Form

Indicate the level of anesthesia you use when providing services for or on behalf of the Applicant
☐Local or Oral ☐IV Conscious Sedation ☐ General Anesthesia

Indicate the
Number of hours per week practiced for or on behalf of the Applicant:_____
Number of Clients treated by you at the Applicant's facilities_____
Weekly:_____ Annually:_____
Number of hours per week you practice in an Emergency Room_____ ☐None
Number of hours per week you engage in private practice: _____
Number of formal or informal consultations with other physicians in the past year: _____
Requested by other physicians_____ Provided by other physicians_____

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

Check the procedures you perform on Clients of the Applicant: (check all that apply)

Arteriography	☐	Hair Transplants/suturing/hairpieces	☐
Dermabrasion/Chemabrasion	☐	Interventional radiology	☐
Hypnosis	☐	Varicose Vein Stripping	☐
Lymphangiography	☐	Open or closed reduction of fractures	☐
Needle biopsies	☐	Percutaneous transluminal angioplasty	☐
Radial or hexagonal keratotomy	☐	*Prenatal care and deliveries	☐
Myelography	☐	Experimental research	☐
*Mohs micrographic surgery	☐	Percutaneous transluminal embolization	☐
Reconstructive/Cosmetic Surgery	☐	Dilation and curettage	☐
Pneumoencephalography	☐	Experimental therapy in human patients	☐
*Acupuncture anesthesia	☐	Non spontaneous, induced abortions	☐
Radiation therapy-deep (includes radium implants)	☐	Surgery other than incisions of boils & superficial abscesses or suturing skin & superficial fascia	☐
Electroshock therapy	☐	Angiography	☐
Amniocentesis	☐	Gastric Bubble	☐
Sterilization Operations	☐	Peritoneoscopy	☐
Isotope Therapy	☐	Chemotherapy	☐
Catheterization	☐	Invasive Diagnostic Tests	☐
AIDS Treatment	☐	Mammography	☐
*Other Surgery	☐		

* Describe on separate sheet of paper

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? If Yes, please give details on a separate sheet. ☐Yes ☐No

Has any hospital or other institution reduced, revoked, restricted or suspended your privileges ? If Yes, give details on a separate sheet. ☐Yes ☐No

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? If Yes, please give details on a separate sheet: ☐Yes ☐No

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? If Yes, please give details on a separate sheet. ☐Yes ☐No

Have you or any of your employees ever been convicted of a crime (other than a motor vehicle citation)? If Yes, please give details on a separate sheet. ☐Yes ☐No

Has any medical practitioner, Medicare/Medicaid patient or insurance plan ever filed a complaint against you with any medical society or organization? If Yes, please give complete details on a separate sheet. ☐Yes ☐No

(In the State of Missouri, the following question does not apply)
Has any insurance carrier ever declined, canceled, rescinded or modified coverage or refused to renew your professional liability coverage? If Yes, give details on a separate sheet. ☐Yes ☐No

Has any claim or suit been brought against you on account of alleged malpractice, error or mistake in the past five years? If Yes, give details for each incident on a separate sheet. ☐Yes ☐No

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? ☐Yes ☐No

Is your current professional liability insurance policy an: ☐Individual Policy ☐Institution Policy

Does your current policy provide coverage for professional employees? ☐Yes ☐No

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	Annual Premium	Claims Made Form?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Date:_____

Signature:_____

(Must be signed and dated by Applicant: Owner/President/CEO/or Executive Director)

Title:_____