



INDIVIDUAL PODIATRISTS APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

The following are representation of facts known by you to be true. You agree that any coverage issued will be contingent upon the truth thereof and upon final approval by the insurance company. *If a policy is issued, this application will become a part of the policy. Please fully complete this application, as an incomplete application cannot be evaluated.*

I. ABOUT YOU

1. Name	2. Date of Birth	3. Social Security No.	4. Professional Degree: <input type="checkbox"/> DPM <input type="checkbox"/> MD <input type="checkbox"/> Other _____
5. Name of Your Practice			
6. Primary Practice Location — Street			
7. City	8. County	9. State	10. Zip

IF YOU OWN MORE THAN ONE LOCATION, COMPLETE THE MULTI-PODIATRIST SUPPLEMENT.

11. Mailing Address if Different from Above			
12. Phone	13. Fax	14. Alternate Phone No.	15. E-mail address
16. Podiatric/Medical School		17. Year Graduated	18. Date you began practice
19. I completed an Internship <input type="checkbox"/>	Residency <input type="checkbox"/> or	# of Years	Year Completed
Preceptorship <input type="checkbox"/>			Name of Hospital/Podiatrist where completed:
20. Narcotic/Drug License Numbers	State(s)	Expiration Date(s)	Please supply copy of license(s).
21. Podiatric/Medical License Number(s)	State(s)	Expiration Date(s)	Please supply copy of license(s).

22. Please provide the name(s) of your professional liability carrier(s) for the last three years, policy number, limits and coverage date. Check if claims-made or occurrence.

Insurance Company	Premium	Policy No.	Policy Limits	Coverage Dates	Type
					<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
					<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence
					<input type="checkbox"/> Claims-Made <input type="checkbox"/> Occurrence

23. Requested policy effective date	24. Retroactive Date
25. LIMITS OF LIABILITY DESIRED (PER CLAIMS/AGGREGATE) Some limits are not available in certain states. <input type="checkbox"/> \$1,000,000/\$3,000,000 <input type="checkbox"/> Other: \$ _____	
26. Deductible amount desired (per claim/aggregate) — NOTE: The deductible does not apply to expense. <input type="checkbox"/> No Deductible <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$ _____	

PLEASE EXPLAIN ALL YES ANSWERS (BELOW) IN THE REMARKS SECTION.

27. Have you practiced without professional liability insurance in the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
28. Has there been a General Liability or Professional Liability claim or suit (settled or pending) made against you?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PLEASE EXPLAIN ALL YES ANSWERS (BELOW) IN THE REMARKS SECTION.

29. Do you have knowledge of any Podiatric 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
30. Has any insurer canceled, declined, rescinded or modified coverage, or refused renewal? Yes No
31. Has any hospital or other institution reduced, revoked, restricted or suspended your privileges? Yes No
32. 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 podiatry? Yes No
33. Has any medical/Podiatric practitioner, Medicare/Medicaid, patient or insurance plan ever filed a complaint against you with any medical society or organization? Yes No
34. 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? Yes No
35. 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 podiatry? Yes No
36. Have you ever been charged with or convicted of a crime other than minor traffic violations? Yes No
37. Do you treat Podiatric conditions which fall outside the areas covered in your state's Podiatric Practice Act or assist on surgeries outside your states Podiatric Practice Act, i.e., hips, knee surgeries? Yes No
38. Do you dispense and/or use any drugs or chemicals that are not approved by the Federal Drug Administration? Yes No
39. Are you a full-time Podiatric school faculty member? If **YES**, how many hours do you teach? Yes No
40. Are you a full-time student enrolled in an accredited Podiatric postdoctoral program? Yes No
41. Are you Board Certified? If **YES**, name of Specialty Board(s). Yes No
42. Are you an employee of a federal or state government? If **YES**, please specify. Yes No

II. ABOUT YOUR PRACTICE

43. Are you practicing as an:

- Employee (no ownership interest) Owner Associate Independent Contractor
 Preceptee Resident Other _____

Type of Practice (check all that apply):

- Solo practice Partnership Corporation Limited Liability Company Associateship
 HMO, PPO, DMO, ETC. Multi-Podiatrist Practice Other _____

44. If you are an employee, who is your employer: _____

45. Do you have any associates? Yes No

If **YES**, list your associates:

Indicate the extent of your association: Share Office Share Employees Share Calls
 Common Billings Independent Contractor Other _____

46. If you are **not** a sole practitioner, please list names of partners or other members of a partnership, professional association or corporation: _____

47. If you are **not** a sole practitioner, please list the full corporate, partnership or association name(s): _____

48. Do you desire coverage on the partnership, Professional Association members or Corporation shareholders who practice with you? Yes No

ALL PARTNERS/OFFICERS MUST BE INSURED BY US TO RECEIVE THIS COVERAGE

49. Have you participated in any risk management seminar or workbook during the last two years? Yes No

If YES, provide information below for possible credit.

Date: _____ Co. Sponsor: _____ Name of Seminar/Workbook: _____
Type of Risk Management: Workbook 1/2 Day Seminar Full Day Seminar

50. Number of hours **YOU** practice per week _____ If less than 20 hours, indicate reason for practicing part-time. _____

51. Do you advertise your professional services in any manner? Yes No

If YES, provide photocopy of yellow page advertisements.

52. Number of Podiatric office personnel:

Employed Podiatrists	Employed Nurses	Employed Nurse Anesthetists	Employed Medical Assistants	Employed Licensed Podiatric Assistants	Employed Physio-Therapists
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53. Number of Independent Contractors (I.C.) Podiatric office personnel:

I.C. Podiatrists	I.C. Nurses	I.C. Nurse Anesthetists	I.C. Medical Assistants	I.C. Licensed Podiatric Assistants	I.C. Physio-therapists
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NOTE: Podiatric professional liability coverage extends to any EMPLOYEE (other than a podiatrist, physician, surgeon, other medical doctor or nurse anesthetist) while acting within the scope of his or her duties.

III. OFFICE PROCEDURES

54. What type of informed consent do you use? Oral Written None
If oral: is chart noted, dated, and initialed by patient? Yes No
55. Do you obtain a complete patient medical history?
 Please attach a copy of your medical history form. Yes No
56. How often do you or your staff update patient medical histories? Each visit Occasionally No policy
 If occasionally, what is your procedure?
57. Do you have written procedures for you and your staff to handle health related emergencies? Yes No
58. Are you and/or your staff certified in Basic Life Support (CPR)? Yes No Certified in ACLS? Yes No
59. Do you follow OSHA and CDC guidelines for infection control? Yes No
60. Do you have a 24-hour emergency phone number for patients to reach you after hours? Yes No
61. Is on-the-spot surgery ever performed on the first visit with a patient (except for nail-related procedures)? Yes No
62. Do you consult with the patient's primary care physician on underlying health conditions, i.e., diabetes, heart, existing infections, etc.? Yes No
63. Do **you** administer General Anesthesia, I.V. or Conscious Sedation?
If YES, fill out the anesthesia supplement. Yes No
64. Do you require certificates of insurance from persons administering anesthesia? Yes No

65. List all locations where you have practiced in the last ten years:

Street	City	State	County	During years

66. List all hospitals and surgery centers at which you currently have privileges and show percentages of work at each location:

If you need a certificate of Insurance, mark the box to the left of the hospital or surgi-center.

Certificate Needed	Location
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	

67. Please check the professional organizations to which you belong:

- Am. College of Foot & Ankle Orthopedics & Medicine (ACFAOM) Am. Board of Podiatric Surgery (ABPS)
 Am. Podiatric Medical Association (APMS) Academy of Ambulatory Foot Surgery (AAFS)
 Am. College of Foot Surgeons (ACFS) Other _____

68. No. of patients YOU treat per week: _____ 69. Number of referrals from other podiatrists each month: _____

70. Please list the annual percentage of procedures you perform. **(Should total 100%)**
 Non Surgical: _____% Soft Tissue Surgery: _____% Osseous Surgery: _____%
 If 5% or less Osseous Surgery, do you refer patients to another podiatrist for surgery? Yes No

