

THE MEDICAL PROTECTIVE COMPANY
Locum Tenens Additional Insured Physician Application

I. GENERAL INFORMATION

If additional space is needed, please attach a separate sheet of paper.

A. _____
LAST NAME FIRST NAME MIDDLE NAME DEGREE

DATE OF BIRTH (M/D/Y) _____ SOCIAL SECURITY NUMBER _____

B. HOME ADDRESS

SUITE NUMBER & STREET CITY STATE ZIP CODE COUNTY

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BUSINESS PHONE HOME PHONE E-MAIL ADDRESS

II. EDUCATIONAL BACKGROUND

A. MEDICAL SCHOOL

NAME OF SCHOOL CITY STATE DEGREE YEAR COMPLETED

IF FOREIGN MEDICAL SCHOOL GRADUATE, ARE YOU CERTIFIED BY THE EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES? NO YES

B. RESIDENCY:

LIST ALL RESIDENT TRAINING LOCATIONS.

1. _____
NAME OF HOSPITAL STATE FROM (MO/YR) TO (MO/YR) TYPE COMPLETED

2. _____
NAME OF HOSPITAL STATE FROM (MO/YR) TO (MO/YR) TYPE COMPLETED

ADDITIONAL TRAINING (FELLOWSHIP, ETC.)

3. _____
NAME OF HOSPITAL STATE FROM (MO/YR) TO (MO/YR) TYPE COMPLETED

C. HAVE YOU PARTICIPATED IN ANY CONTINUING MEDICAL EDUCATION WITHIN THE LAST THREE YEARS?

YES NO If "yes", how many category 1 credit hours? _____

D. PLEASE PROVIDE DETAILS ANY OTHER RELEVANT TRAINING IN THE AREA/SPECIALTY FOR WHICH YOU ARE PROVIDING LOCUM TENENS SERVICES: _____

E. STATES IN WHICH YOU HOLD A LICENSE TO PRACTICE MEDICINE:

1. STATE _____ LICENSE# _____

2. STATE _____ LICENSE# _____

3. STATE _____ LICENSE# _____

4. STATE _____ LICENSE# _____

III. RATING INFORMATION

A. WHAT IS YOUR PRESENT SPECIALTY? _____ SUB-SPECIALTY? _____

B. AMERICAN BOARD CERTIFIED? Yes No _____
SPECIALTY BOARD DATE CERTIFIED

IF NO, ARE YOU BOARD ELIGIBLE? Yes No

IF YES, WHEN DO YOU PLAN ON TAKING YOUR BOARDS? _____

C. PROCEDURES? *(Please respond carefully and completely, as coverage may not apply for types of procedures that are different from those presently performed by the physician you are replacing)*
IN YOUR LOCUM TENENS CAPACITY, PLEASE LIST ANY PROCEDURES YOU WILL BE PERFORMING THAT ARE DIFFERENT FROM THOSE PRESENTLY PERFORMED BY THE PHYSICIAN YOU ARE REPLACING _____

D. OTHER COVERAGE?
DO YOU HAVE OTHER PROFESSIONAL LIABILITY COVERAGE PRESENTLY IN PLACE, WHICH MAY ALREADY BE APPLICABLE FOR YOUR LOCUM TENENS ACTIVITIES? Yes No

IF YES, PLEASE EXPLAIN WHY YOU ARE SEEKING COVERAGE AS AN ADDITIONAL INSURED: _____

IV. ADDITIONAL PROFESSIONAL INFORMATION

A. Please fully explain any "yes" answer on a separate page:

1. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license or medical license revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? Yes No
2. Have you had any professional liability insurance refused, canceled or non-renewed? Yes No
3. Have you incurred or become aware of having an illness or physical disability that impairs or could impair your ability to practice your medical specialty? (e.g. alcoholism, convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, abuse, addiction of narcotics or other controlled substances, etc.) Yes No

If Yes, state illness or disability, date(s) and identify treating physician in space provided below. In the event of any such impairment, a statement from your physician attesting to your fitness to practice your specialty must accompany this application. Further statements may be requested as necessary by the Company to complete the underwriting of your application.

Type	Duration	Treating Physician (Name & Address)
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V. LOSS INFORMATION (IMPORTANT! COMPLETE CAREFULLY)

Complete and attach a Claim Information Form for EACH such claim, potential claim, or suit.

A. Are you now, or have you in the past ten (10) years been involved, directly or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services? Yes No
If "Yes", how many? _____
If "Yes", have these been reported to your insurer? Yes No

B. Do you have knowledge of any claims, potential claims, or suits in which you may become involved, including without limitation, knowledge of any alleged injury arising out of the rendering or failing to render professional services which may give rise to a claim? Yes No
If "Yes", have these been reported to your insurer? Yes No

Claim/Suit Information Form

*Note: Additional documentation (office/hospital records) may be requested by the Underwriting Department.
Additional Forms are Available Please complete one of these pages for each claim, potential claim, or suit.*

Name of Applicant: _____

1. Patient/Claimant Information

Patient/Claimant Name Age Sex

2. Date(s) of treatment and/or surgery which led to the allegations against you. _____
Date (MM/YY)

3. Nature of allegations in the claim or suit: _____

4. Was a suit ever filed? Yes No If Yes, when _____
Date (MM/YY)

5. Name other doctor(s), hospital(s) or health care provider(s), if any, involved in the claim or suit:

6. Disposition or current status of claim or suit:

a. OPEN
Indicate case value established by carrier, if known (in \$) _____

b. CLOSED
Was this matter closed with your consent? Yes No
Was payment made? Yes No
If No, was claim or suit withdrawn? Yes No
If Yes, indicate total amount of settlement or award \$: _____
Amount paid on your behalf \$: _____
Settlement or award date: _____

7. Defending insurance carrier information: _____

(Name of Insurance Carrier Defending You) Policy Number

8. Please attach a narrative description of the medical/dental facts; (must include, but not limited to the type of treatment and/or surgery; your involvement).

(Attach a separate sheet of paper if additional space is needed).

VII. STATE STATUTORY REQUIREMENT

NOTE: All applicants must read and initial the following:

Any person who knowingly files an application for insurance or statement of claim 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 also punishable by criminal and/or civil penalties in certain jurisdictions.

Initial Here

VIII. PLEASE READ AND SIGN

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the Company.

I agree to notify the Company if there is any future material change in any answer to this application, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other physician, firm, or professional association.

I UNDERSTAND AND AGREE THAT THE COMPLETION OF THIS APPLICATION DOES NOT BIND THE COMPANY TO ISSUE, NOR ME TO PURCHASE, A CONTRACT OF INSURANCE, PROVIDED HOWEVER, IF I AM ISSUED INSURANCE BY THE COMPANY, I UNDERSTAND AND AGREE THAT ANY MATERIAL MISREPRESENTATION OR OMISSION BY ME IN THIS APPLICATION MAY ACT TO VOID SUCH CONTRACT OF INSURANCE AND MAY GIVE THE COMPANY A RIGHT TO RESCIND SUCH CONTRACT.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, and other entities listed in this application to verify and/or ascertain information regarding my credentials and background both prior to and, if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Date Signed _____

Signature

REMINDER: If you answered "yes," to questions in the Loss Information Section, you must complete a Claim Information Form for EACH claim or suit (page 3).