



## Physicians And Surgeons Professional Liability Renewal Application

### A. Applicant Information

Name of Applicant (First, Middle, Last):	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Other	MMIC Policy Number:
		Specify Other:

Applicant's Business Address (Street, City, State, Zip Code):	County:
---	---------

Business Phone:	Fax:	E-mail:
-----------------	------	---------

Website:

Applicant's Home Address (Street, City, State, Zip Code):

Home Phone:	Fax:	E-mail:
-------------	------	---------

Mailing/Billing Address: <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Other (specify) Other:	Business Manager / Contact Person:
---	------------------------------------

Telephone:	Fax:	E-mail:
------------	------	---------

Type of Practice:  Individual  Intern/Resident  Fellowship  Employee  Independent Contractor  Owner  
 Partner  Other (Specify):

Are you currently enrolled in a Patient's Compensation Fund (PCF)?  Yes  No  
 If yes, answer the following question and indicate the fund name.

Have you, at all times subsequent to your retroactive date, been continually qualified/covered by the state fund?  Yes  No  
 Kansas Healthcare Stabilization Fund  Nebraska Excess Liability Fund  Wisconsin Patients' Compensation Fund  
 Other (specify):

Are you a member of a network, alliance or IPA?  Yes  No If yes, indicate the name:

### B. Practice Information

1. If you are employed, indicate the name of your employer:

2. If you are an independent contractor, name each entity with which you have contracted healthcare services:

\_\_\_\_\_

3. List each professional corporation, association, partnership or other healthcare related entity in which you have an ownership:

Name	Description of Interest	% of Practice

**Complete one Healthcare Corporate Application for each organization listed above, if coverage is desired.**

4. If you, as an individual, employ or contract physicians or surgeons, complete the following:

Employee or Contractor Name	Specialty*	Category* (1 through 5) (see question D1)	Procedures Performed* (see question D4)	Policy # (if insured by MMIC)	Limit of Liability

\*Not necessary to complete if insured by MMIC.

5. If you, as an individual, employ or contract other medical professionals, complete the following:

Type	Number	Employment	Current Insurer	MMIC Policy # (if applicable)
Physician/Surgeon Assistants		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		
Nurse Anesthetists		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		
Nurse Midwives		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		
Nurse Practitioners		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		
Perfusionists		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		
Podiatrists		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		
Dentists		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		
RNs/LPNs/LVNs		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		
Other (describe):		<input type="checkbox"/> Employee <input type="checkbox"/> Contractor		

**C. Specialty / Work Experience**

1. What is your medical specialty? \_\_\_\_\_ What is your medical sub-specialty? \_\_\_\_\_

2. Are you certified by an approved specialty board?  Yes  No If yes, certifying board name(s): \_\_\_\_\_  
 Date(s) of initial certification: \_\_\_\_\_ Date(s) of recertification: \_\_\_\_\_

3. If you are not certified, are you board eligible?  Yes  No If yes, date eligibility expires: \_\_\_\_\_

4. List each state where you are licensed to practice, license number and the percentage of patients seen in each state:

State	License Number	% of Patients

5. Indicate the name and location of all facilities, including nonhospital facilities, where you hold staff or courtesy privileges:

Name/Location	Name/Location

6. List all places where you have practiced your profession during the past 5 years:

Facility/Practice	Dates (month/year to month/year)
	to
	to
	to
	to
	to

7. Has there been any change in your practice or specialty during the past five years?  Yes  No  
 If yes, describe changes: \_\_\_\_\_

**D. Classification**

1. Indicate each of the following that you perform. Check each box that applies.
- Category 1** No surgical procedures performed other than incision of boils and superficial abscess, suturing of skin and superficial fascia or circumcision.
  - Category 2** Assist in surgery on your own patients and/or perform minor surgical procedures.
  - Category 3** Obstetrical procedures and/or prenatal care beyond the first trimester not including c-sections.
  - Category 4** All other types of surgery and operations performed under general or regional anesthesia.  
 Number of surgeries performed annually: \_\_\_\_\_
  - Category 5** Administration of anesthesia (other than local)

2. Do you perform obstetrical procedures?  Yes  No If yes, answer the following questions:  
 Average number of deliveries you perform annually: \_\_\_\_\_ Number of c-sections: \_\_\_\_\_ Number of VBACs: \_\_\_\_\_

3. Indicate the percentage of time devoted to the following medical and/or surgical activities: (Total should equal 100%)

Percentage (Non-Surgical)	Percentage (Non-Surgical)	Percentage (Surgical)
<input type="checkbox"/> Administrative Medicine	<input type="checkbox"/> Nephrology	<input type="checkbox"/> Abdominal
<input type="checkbox"/> Aerospace Medicine	<input type="checkbox"/> Neurology	<input type="checkbox"/> Bariatric
<input type="checkbox"/> Allergy	<input type="checkbox"/> Nuclear Medicine	<input type="checkbox"/> Cardiac
<input type="checkbox"/> Anesthesiology	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Cardiovascular
<input type="checkbox"/> Broncho-Esophagology	<input type="checkbox"/> Obstetrics/Pre-Natal Care	<input type="checkbox"/> Colon & Rectal
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Occupational Medicine	<input type="checkbox"/> Dermatology
<input type="checkbox"/> Dermatology	<input type="checkbox"/> Oncology	<input type="checkbox"/> Endocrinology
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Foot and Ankle
<input type="checkbox"/> Emergency Medicine	<input type="checkbox"/> Orthopedics	<input type="checkbox"/> Gastroenterology
<input type="checkbox"/> Endocrinology	<input type="checkbox"/> Otolaryngology	<input type="checkbox"/> General
<input type="checkbox"/> Family Practice/General Practice	<input type="checkbox"/> Otorhinolaryngology	<input type="checkbox"/> Geriatrics
<input type="checkbox"/> Fetal and Maternal Medicine	<input type="checkbox"/> Pain Management*	<input type="checkbox"/> Gynecology
<input type="checkbox"/> Forensic Medicine	<input type="checkbox"/> Pathology	<input type="checkbox"/> Hand
<input type="checkbox"/> Gastroenterology	<input type="checkbox"/> Pediatrics	<input type="checkbox"/> Head & Neck
<input type="checkbox"/> General Preventive Medicine	<input type="checkbox"/> Pharmacology-Clinical	<input type="checkbox"/> Laryngology
<input type="checkbox"/> Genetic Counseling	<input type="checkbox"/> Psychiatry	<input type="checkbox"/> Neonatal
<input type="checkbox"/> Geriatrics	<input type="checkbox"/> Physical Medicine/Rehabilitation	<input type="checkbox"/> Nephrology
<input type="checkbox"/> Gynecology	<input type="checkbox"/> Psychiatry	<input type="checkbox"/> Neurosurgery
<input type="checkbox"/> Hematology	<input type="checkbox"/> Psychoanalysis	<input type="checkbox"/> Obstetrics
<input type="checkbox"/> Hospitalist	<input type="checkbox"/> Psychosomatic Medicine	<input type="checkbox"/> Obstetrics-Gynecology
<input type="checkbox"/> Hypnosis	<input type="checkbox"/> Public Health	<input type="checkbox"/> Ophthalmology
<input type="checkbox"/> Infectious Diseases	<input type="checkbox"/> Pulmonary Diseases	<input type="checkbox"/> Orthopedic excluding Spinal Surgery
<input type="checkbox"/> Intensive Care Medicine	<input type="checkbox"/> Radiology	<input type="checkbox"/> Orthopedic including Spinal Surgery
<input type="checkbox"/> Internal Medicine	<input type="checkbox"/> Rheumatology	<input type="checkbox"/> Otorhinolaryngology
<input type="checkbox"/> Laryngology	<input type="checkbox"/> Rhinology	<input type="checkbox"/> Plastic
<input type="checkbox"/> Legal Medicine	<input type="checkbox"/> Sports Medicine	<input type="checkbox"/> Plastic-Otorhinolaryngology
<input type="checkbox"/> Neonatology	<input type="checkbox"/> Weight Reduction/Control*	<input type="checkbox"/> Thoracic
<input type="checkbox"/> Neoplastic Diseases	<input type="checkbox"/> Other*	<input type="checkbox"/> Traumatic
		<input type="checkbox"/> Urological
		<input type="checkbox"/> Vascular
		<input type="checkbox"/> Other*

\*Describe in Comments section.

4. Please check the following medical procedures you perform:

- |  |  |
|--|--|
| <input type="checkbox"/> Autologous Fat Injection  | <input type="checkbox"/> Epidurals   |
| <input type="checkbox"/> Angiography   | <input type="checkbox"/> ERCP (Endoscopic Retrograde Cholangiopancreatography)   |
| <input type="checkbox"/> Arteriography   | <input type="checkbox"/> Lasers (describe)   |
| <input type="checkbox"/> Botox Injections  | <input type="checkbox"/> Laparoscopy   |
| <input type="checkbox"/> Catheterization – arterial, cardiac, or diagnostic, other than:               | <input type="checkbox"/> Lymphangiography  |
| a. Occasional emergency insertion of pulmonary wedge,  | <input type="checkbox"/> Liposuction   |
| pressure recording catheters, or temporary pacemakers.   | <input type="checkbox"/> Pneumoencephalography   |
| b. Urethral catheterization  | <input type="checkbox"/> Pneumatic or mechanical esophageal dilation (not with buogie or olive)  |
| c. Umbilical cord catheterization for diagnostic purposes or   | <input type="checkbox"/> Needle biopsy (describe)  |
| for monitoring blood gasses in newborns receiving oxygen.  | <input type="checkbox"/> Myelography   |
| <input type="checkbox"/> Chelation therapy   | <input type="checkbox"/> Radiation therapy   |
| <input type="checkbox"/> Closed fracture reduction – other than fingers or toes                        | <input type="checkbox"/> Radiopaque dye injections into blood vessels, lymphatics, sinus tracts and fistulae   |
| <input type="checkbox"/> Colonoscopy   | <input type="checkbox"/> Vasectomies   |
| <input type="checkbox"/> Cryosurgery – other than use on benign or premalignant dermatological lesions | <input type="checkbox"/> Other procedure by which the body or body cavity is penetrated or entered by use of a tube, needle, device or ionizing radiation (describe) |
| <input type="checkbox"/> Conscious sedation  |  |
| <input type="checkbox"/> D & C performed under local anesthesia  |  |
| <input type="checkbox"/> Discograms  |  |
| <input type="checkbox"/> ECT (describe): _____   |  |
- NONE OF THE ABOVE**

### E. Underwriting Questions

Explain any “yes” answers to the following questions in the Comments section.

- Do you staff an emergency room for purposes other than to maintain hospital privileges?  
If yes, include hospital name, location, number of hours per month and relationship in your explanation.  Yes  No
- Do you practice in or staff an urgi-center or similar minor emergency clinic?  Yes  No



