

7. Based upon the following, check the appropriate box indicating the extent of surgery/procedures you will be performing while moonlighting:
- a) No surgery
 - b) No surgery except incision of boils, cysts, other superficial abscesses, or suturing of minor lacerations
 - c) Pregnancy terminations or D&Cs.....
 - d) Obstetrics – please describe.....
 - e) Assisting in surgery.....
 - f) Major surgery – includes operations in or upon any body cavity, including but not limited to the cranium, thorax, abdomen or pelvis. It also includes removal of tumors, open bone fractures, amputations, plastic surgery, and most other procedures done under general, spinal, or caudal anesthesia

8. What other procedures or minor surgery will you perform while this moonlighting policy is in force? _____

9. Where will you be moonlighting? Please describe the nature of each practice location (e.g., laboratory, private physician's office, urgent care, industrial clinic, emergency room).

a) Name (employed or contracted by): _____ Name (employed or contracted by): _____
 Address: _____ Address: _____

 How many hours per week? _____ How many hours per week? _____
 Type of facility: _____ Type of facility: _____

10. Please answer the following questions and fully explain any "Yes" answers on a separate sheet of paper and attach:
- a) Has your license to practice medicine or dispense narcotics ever been denied, revoked, suspended, or voluntarily surrendered or subject to probationary terms (in any jurisdiction)?

	Medical License	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	DEA License	Yes <input type="checkbox"/>	No <input type="checkbox"/>
 - b) Has your membership in any medical society or professional organization ever been denied, suspended, revoked, or voluntarily surrendered (other than for relocation of your practice)?.....Yes No
 - c) Have you ever been subject to governmental agency, medical society, or professional society disciplinary proceedings resulting in reprimand, censure, sanction, or modification of practice, either voluntary or involuntary, or are you currently the subject of an administrative proceeding or review by any such agency or society? Yes No
 - d) Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? (NOTE: A conviction record will not automatically bar or disqualify you from obtaining insurance.)..... Yes No
 - e) Has any application for hospital staff privileges ever been denied or restricted? Yes No
 - f) Have your hospital privileges ever been modified (voluntarily or involuntarily), revoked or non-renewed, or have you been subject to probation or disciplinary action? Yes No
 - g) Has your professional liability insurance ever been declined, cancelled, refused renewal, or issued on special terms (e.g., premium surcharge, deductible)? Yes No
 - h) Have you ever had or become aware of having an illness or physical disability that impairs or could impair your ability to practice your medical profession (e.g., alcoholism, convulsive disorders, mental illness, multiple sclerosis, narcotics addiction, rheumatoid arthritis, HIV, etc.)? If "Yes," on a separate sheet of paper, state illness or disability with date(s) and provide the name of and a statement from your treating physician attesting to your fitness to practice your profession. Yes No
 - i) Has any claim or suit for alleged malpractice ever been brought against you or your professional corporation? If "Yes," give full details on a separate sheet of paper..... Yes No

APPLICANT'S REPRESENTATION (READ CAREFULLY)

It is hereby understood that if this application results in a policy being issued, coverage under this policy will be limited to direct patient treatment provided within the scope of your employment by the employers listed in item 9. The applicant agrees to notify Physicians Insurance, in writing, of changes in his/her answer to question 9 and await approval of coverage for said change from Physicians Insurance prior to beginning employment with the new employer as a condition precedent to coverage under the policy.

I hereby represent that the information continued in this application and any supplementary submission is complete and true and that no material facts which are reasonably likely to influence the judgment of Physicians Insurance in considering this application have been omitted. I agree that this shall be the basis of the policy of insurance requested and that I will notify Physicians Insurance of any changes contained herein.

APPLICANT'S AUTHORIZATION AND RELEASE (READ CAREFULLY)

I acknowledge that as a condition precedent to acceptance of this application and any future renewal thereof, an inquiry and investigation of my professional background, qualifications, and competence, including such other underwriting or claim matters as are deemed relevant, may be conducted by Physicians Insurance or its duly authorized representatives. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, their insurance consultants or agents, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any attending or treating physicians, the Washington Monitored Treatment Program, any prior insurance carriers, prior employers or professional associates and Physicians Insurance or its duly authorized representatives. I hereby release and discharge the providers of information, Physicians Insurance, its duly authorized representatives and the members or consultants of any established peer review committees from any and all legal liabilities which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed in good faith, in connection with any inquiry or investigation initiated by Physicians Insurance or its duly authorized representatives.

Applicant's Signature

Date

Washington State law requires us to inform you of the following: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Please return to:

Seattle Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
PO Box 91220
Seattle, WA 98111
(206) 343-7300 (800) 962-1399
F (206) 343-7100

Eastern Regional Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
421 W. Riverside Avenue, Suite 1200
Spokane, WA 99201
(509) 456-5868 (800) 962-1398
F (509) 456-0821

