

Please answer all questions.

<b>NAME</b> _____ <b>OFFICE PHONE</b> _____
<b>ADDRESS</b> _____
_____

1. Do you perform refractive surgery?  Yes  No

If so, which types of refractive surgery do you perform and approximately how many surgeries per month do you perform of each?

- LASIK \_\_\_\_\_
- PRK \_\_\_\_\_
- RK \_\_\_\_\_

2. Please provide information regarding your training and certification for each type of surgery identified above that you perform:

\_\_\_\_\_

\_\_\_\_\_

3. Which laser do you use? \_\_\_\_\_

4. Are you certified by the laser manufacturers?  Yes  No

5. Does all of your usage of the laser equipment, including hardware and software, fall within FDA guidelines?  Yes  No

6. To date, approximately how many of each surgery have you performed? \_\_\_\_\_

7. What is your total average number of all patients seen per week? \_\_\_\_\_

How many refractive surgeries do you perform per week \_\_\_\_\_ or per month \_\_\_\_\_?

8. Do you provide all pre- and post-operative care and follow-up?  Yes  No  
If no, please provide information regarding your evaluation pre- and post-operatively. \_\_\_\_\_

\_\_\_\_\_

If optometrists provide any of this care, please describe your practice relationship with them (e.g., employees, independent contractors, independent practices). \_\_\_\_\_

\_\_\_\_\_

9. How many pre-operative visits are scheduled with the patient prior to surgery? \_\_\_\_\_  
 How many days in advance are these scheduled? \_\_\_\_\_  
 Which of these visits and evaluations are conducted by you personally? \_\_\_\_\_
10. At what intervals do you schedule post-operative follow-up visits? \_\_\_\_\_
11. Please describe in detail your informed consent process. Please attach a copy of the informed consent form you use. \_\_\_\_\_  
 \_\_\_\_\_
12. What percentage of potential candidates do you reject? \_\_\_\_\_
13. Please include a list of contraindications for surgery: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
14. Please describe other circumstances under which a patient might be rejected as a candidate for surgery: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
15. Please identify **all** facilities where you perform these surgeries.
- Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_
16. At which hospitals do you hold privileges? \_\_\_\_\_  
 \_\_\_\_\_
17. Please describe any marketing or promotion of refractive surgery that you do:  
 \_\_\_\_\_  
 \_\_\_\_\_

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 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.

Date \_\_\_\_\_ Physician Signature \_\_\_\_\_