Physicians Insurance
A MUTUAL COMPANY

LOCUM TENENS AND/OR PER DIEM APPLICATION

IMPORTANT:
Complete answers will expedite processing.

Please submit a current curriculum vitae **or** State Practitioner Application (WPA, etc.) with this application.

SECTION I: COVERAGE INFORMATION

- Are you an addition to staff (Per Diem)? Yes ○ No ○
- Are you covering for a provider while that provider is not working (LT)? Yes ○ No ○
- Name of clinic or provider for which you'll be covering: _____

  Name of clinic to which the above physician belongs (if not a solo physician): _____
- Desired dates of coverage: _____ to _____

  If days are not consecutive, please indicate actual coverage dates: _____
- Principal medical specialty: _____

SECTION II: APPLICANT INFORMATION

Name: _____ DOB: _____

Social Security Number: _____ Male ○ Female ○

In which states are you licensed to practice? _____

Home address: _____

Phone number: _____ E-mail address: _____

Board Certification: _____ _____ _____
Name of Board | Date certified | Recertified

If you are not Board Certified, have you taken and failed board exams? Yes ○ No ○

Are you Board eligible? Yes ○ No ○ Date eligibility expires: _____

If not Board Certified and/or Board eligible, please explain in the "REMARKS" section.

SECTION III: IF ANY ANSWER TO QUESTIONS 19 THROUGH 34 IS "YES," USE THE "REMARKS" SECTION TO PROVIDE DETAILS. PROVIDING ADEQUATE DETAIL AND DOCUMENTATION WILL ASSIST US IN EXPEDITING OUR UNDERWRITING REVIEW.

- Has your license to practice medicine or dispense narcotics in any jurisdiction **ever** been limited, denied, revoked, suspended, or voluntarily surrendered or subjected to probationary conditions, or have proceedings towards any of those ends been instituted against you?

  Medical License Yes ○ No ○

  DEA License Yes ○ No ○
- Have any complaints **ever** been filed against you with a governmental agency, medical or professional society, or other medical entity? Yes ○ No ○
- Have you ever been subject to a governmental agency, medical or professional society, or other medical entity's disciplinary proceedings or reviews, or have you ever been notified of an intent to pursue such action? Yes ○ No ○

- If "Yes," did the proceedings or review result in reprimand, censure, sanction, or modification of your practice, either voluntary or involuntary, or are you currently the subject of an administrative proceeding or review by such agency or society?

  Yes ○ No ○

- Have you **ever** been convicted for an act committed in violation of any law or ordinance other than traffic offenses?

  Yes ○ No ○

  NOTE: A conviction record will not automatically bar or disqualify you from obtaining insurance.

- Have you **ever** been charged or convicted of a felony? Yes ○ No ○
- Have you **ever** been under punitive or disciplinary observation, preceptorship, or sponsorship in a hospital, or has any hospital notified you of its intent to pursue such action? Yes ○ No ○
- Have your hospital privileges **ever** been restricted, suspended, revoked, non-renewed, or denied, or has any hospital notified you of its intent to pursue such action? Yes ○ No ○
- Has the threat or avoidance of disciplinary action **ever** caused you to voluntarily relinquish a medical staff membership, clinical privilege, professional license, or narcotics registration? Yes ○ No ○
- Has any professional liability insurance carrier **ever** declined, cancelled, refused renewal, or issued coverage on special terms (premium surcharge, deductible, etc.), or have you ever been notified of impending action of this nature? Yes ○ No ○
- Have you **ever** been diagnosed with, been treated for, or are currently being treated for alcoholism and/or chemical dependency? Yes ○ No ○
- Have you **ever** incurred or become aware of having an illness or physical disability that impairs or could impair your ability to practice your medical profession (e.g., convulsive disorders, mental illness, multiple sclerosis, rheumatoid arthritis, hearing or vision impairment, Hepatitis B or C, HIV)? Yes ○ No ○
- **If "Yes," in the "REMARKS" section, 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.**
- Has **any** claim or suit for alleged malpractice **ever** been brought against you or your professional corporation? Yes ○ No ○
- **If "Yes," give full details on the Claim Information Supplement, which is attached as part of this application, for ALL claims even if closed for no payment.**
- Have you **ever** been accused of sexual misconduct? Yes ○ No ○
- Have you **ever** had contact of a sexual nature with a patient or former patient? Yes ○ No ○
- Have you practiced without insurance at **any** time? Yes ○ No ○

SECTION V - REMARKS

Pg. #	Question #	
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CLAIM INFORMATION

(NOTE: please make copies of this form for additional claims)

1. Name of patient: _____ 2. DOB: _____ 3. Sex:
4. Allegation:

5. Date of incident: _____ 6. Date reported: _____
7. Insurance carrier: _____

   Was a lawsuit filed? Yes ○ No ○
8. Additional defendants: _____
9. Location of occurrence: _____
10. Disposition of claim: _____
11. Amount of settlement or judgment: $_____

    If claim is still open, reserve amount: $_____

The following questions should be answered in adequate clinical detail to allow proper evaluation. Please attach copies of patient's charts and operative notes as appropriate. Attach additional sheets as required, in duplicate.

12. Condition and diagnosis at time of incident:

13. Date and description of treatment rendered:

14. Condition of patient subsequent to treatment:

I understand information submitted herein becomes part of my Professional Liability Insurance Application as submitted.

_____ _____

Applicant's Signature **Date**

APPLICANT'S REPRESENTATION (READ CAREFULLY)

I hereby represent that the information contained in this application and any supplemental 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 locum tenens coverage provided to me 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, an inquiry and investigation of my professional background, qualification 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, 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 consultant 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.

I understand that signature of this application does not bind the company to complete this insurance.

(A photocopy or facsimile of this Authorization shall be considered as effective and valid as the original.)