Physicians Insurance
A MUTUAL COMPANY

MIDLEVEL PROVIDER APPLICATION

Please include the following with this application:

1. Current curriculum vitae
2. Copy of professional liability declarations page, if applicable (see Section II, question 4)

Unanswered questions or missing documentation may result in delayed processing of the application.

SECTION I – APPLICANT INFORMATION

1. **Name**: _____
   First middle last
2. **DOB**: _____ mo/day/yr
3. ☐ **Male** ☐ **Female**
4. **Social Security Number**: _____
5. **Phone number**: _____ (area code) + number
6. **Home address**: _____
   Street City State Zip code
7. **License Number**: _____
8. **Email**: _____

SECTION II – PRACTICE INFORMATION

1. Effective Date: _____
2. Number of hours worked per week: _____
3. Name of physician or clinic for which you will be working: _____
   Policy number: _____
   Are you employed or contracted by the above physician or clinic? ☐ Employed ☐ Contracted
4. Do you currently carry your own separate professional liability policy that will act as primary coverage for this practice?
   Yes ☐ No ☐
   If "Yes," please include a copy of that declarations page with the completed application form.
5. Professional Designation: ☐ Physician Assistant ☐ Nurse Practitioner ☐ Certified Nurse Midwife ☐ Certified Registered Nurse Anesthetist
6. What is your specialty area of practice? _____
7. Will you be working at a location with no physician present? Yes ☐ No ☐
8. If you are an ARNP or PA, will your practice include obstetrical patient care? Yes ☐ No ☐
9. Send confirmation of coverage to the following hospitals where I am credentialed:
   Hospitals: _____

SECTION III – PROFESSIONAL BACKGROUND

1. 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?

   a. Medical License Yes ☐ No ☐
   b. DEA License Yes ☐ No ☐

2. Have any complaints **ever** been filed against you with a governmental agency, medical or professional society, or other medical entity? Yes ☐ No ☐
3. 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 ☐
4. If "Yes," did the proceedings or review result in reprimand, censure, sanction, or modification or 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 ☐
5. 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.
6. Have you **ever** been charged or convicted of a felony? Yes ☐ No ☐
7. 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 ☐
8. 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 ☐
9. 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 ☐
10. 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 ☐
11. Have you **ever** been diagnosed with, been treated for, or are currently being treated for alcoholism and/or chemical dependency? Yes ☐ No ☐
12. 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.
13. 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.
14. Have you **ever** been accused of sexual misconduct? Yes ☐ No ☐
15. Have you **ever** had contact of a sexual nature with a patient or former patient? Yes ☐ No ☐

IF ANY ANSWER TO QUESTIONS 1 THROUGH 15 IS "YES," USE THE "REMARKS" SECTION BELOW TO PROVIDE DETAILS.

REMARKS

_____

_____

_____

_____

_____

CLAIM INFORMATION

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

☐ **No 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 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 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.

I understand that this application does not bind the company to provide this insurance. If coverage is issued, the limits of liability will be shared with the named insured under whose policy coverage is provided.

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

_____

Print Name

_____ _____

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.