Missouri Doctors Mutual Insurance Company (NAIC #11964)

Locum Tenens Application

601 Francis Street, Saint Joseph, Missouri 64501
Tel (800) 264–5959 Fax (800) 955–1855

Before you begin

- Please use black ink when completing this application. Type or print complete answers to every question or write "N/A" for *not applicable*. **Failure to provide complete information will delay the processing of this application.** Use the 'notes' section to amplify your answers or to provide additional remarks. If you are unsure how to answer a question, call our underwriting department at (816) 676–6363 or (800) 264–5959 between 8:30 AM and 5 PM Monday through Friday.
- An attached curriculum vitae will not suffice; this application must be completed.
- This completed application, together with any supplementary information, must be personally reviewed, signed and dated in ink by the applicant.

1 Locum Tenens Coverage For

Practice name			Policy number
Physician(s) name			
Physician(s) name			
Street			Suite
City	State	Zip	County
Office phone ( ) -	Contact person		

2 Personal

First name	Middle name	Last name		Suffix (Jr./Sr./III)
Maiden name	Degree (MD/DO) / other)	Date of Birth / /	Age in years	Social security number
BNDD number	DEA number	NPI		

3 Residential Address

Street			Apt
City	State	Zip	County
Home phone ( ) -	Home email	Business phone ( ) -	

Professional Profile

4-9

Please use the 'notes' section to explain any "Yes" answers in detail.

4 Have you ever been denied board certification or recertification? Yes ☐ No ☐

5 Has any hospital or other entity ever refused, limited, restricted, suspended, revoked, or is currently investigating a complaint regarding your clinical or staff privileges? Yes ☐ No ☐

6 Have you ever been investigated by any state licensing board, narcotics board, DEA or other governmental or regulatory agency, or has your license to practice or your state or federal narcotics license ever been denied, restricted, suspended, revoked, voluntarily surrendered or limited in any way? Yes ☐ No ☐

7 Have you ever been indicted or convicted of a crime other than a minor traffic violation? Yes ☐ No ☐

8 Have you ever been investigated, suspended, restricted, penalized or put on probation by any governmental health program (for example, Medicare or Medicaid)? Yes ☐ No ☐

9 Has your membership in any professional society or association ever been refused, censured, suspended or revoked? Yes ☐ No ☐

Professional Profile

continued…

10-26

Please use the 'notes' section to explain any "Yes" answers in detail.

10 Has any complaint ever been made against you to any licensing board? (If yes, explain in the notes section the final result of any investigation by that board.) Yes ☐ No ☐

11 Has a judgement ever been entered against you in a civil lawsuit, other than for medical malpractice? Yes ☐ No ☐

12 Are you now, or have you ever been, addicted to alcohol, dependent upon narcotic drugs, been afflicted with mental illness, or have you ever received treatment for alcoholism, narcotic addiction or mental illness? Yes ☐ No ☐

13 Do you have any chronic illness or physical defect that impairs or could impair your ability to practice your specialty? Yes ☐ No ☐

To Be Filled Out For Locum Tenens Position.

14 Do you perform surgery—except for incision of boils, suturing of skin or superficial fascia? Yes ☐ No ☐

15 Do you perform major surgery? (Includes operations in or upon any body cavity including but not limited to, the cranium, thorax, abdomen, or pelvis, or any other operation which, because of the condition of the patient or length of circumstance, presents a distinct hazard to life. It also includes removal of tumors, open fractures, amputation, removal of any gland or organ, plastic surgery, and any other operation done under general anesthesia, and also includes tonsillectomies, adenoidectomies and caesarean sections.) Yes ☐ No ☐

16 Do you assist–only at surgery? If you answer "Yes", complete the following: ▼ Yes ☐ No ☐

Number of own patients per year? _____ Number of other patients per year? _____

17 Do you provide any surgical services to patients in any setting in which another person provides the postoperative follow-up care for that procedure? Yes ☐ No ☐

18 Do you perform general anesthesia? If "Yes", check as appropriate below. ▼ Yes ☐ No ☐

☐ Hospital ☐ Non-hospital facility ☐ Office

19 Do you supervise CRNA's who provide general anesthesia? Yes ☐ No ☐

20 Do you perform obstetrical procedures? Yes ☐ No ☐

21 Do you perform cesarean sections? If "Yes", check as appropriate below. ▼ Yes ☐ No ☐

☐ Elective ☐ Emergency

22 Do you perform abortions? If "Yes", check as appropriate below. ▼ Yes ☐ No ☐

☐ First trimester ☐ Second trimester ☐ Third trimester

23 Do you practice in an emergency room? If you answer "Yes", complete the following: ▼ Yes ☐ No ☐

Hours per month? _____

24 If you are a radiologist:

▶ Is your practice limited to diagnostic radiology? Yes ☐ No ☐

▶ Do you perform radiation therapy or other invasive procedures such as angiography or arteriography? Yes ☐ No ☐

▶ Do you supervise a hospital X-ray lab other than your own? Yes ☐ No ☐

25 Do you provide regular medical or surgical care to professional athletes? Yes ☐ No ☐

26 Have you performed any new procedures during the past year, i.e. procedures not previously performed by you? Yes ☐ No ☐

▼

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Procedures Profile

27 In your locum tenens capacity, please list any procedures you will be performing that are different from those presently performed by the physician you are replacing ▼

(Please respond carefully and completely, as coverage may not apply for types of procedures that are different from those presently performed by the physician you are replacing)

____

____

Specialty

28-32

28

Primary specialty	% of Practice	Years practicing primary specialty

29 Are you board certified in your primary specialty? If yes, name the board. ▼ Yes ☐ No ☐

Name of the board	Date
	/ /

30

Secondary specialty	% of Practice	Years practicing secondary specialty

31 Are you board certified in your secondary specialty? If yes, name the board. ▼ Yes ☐ No ☐

Name of the board	Date
	/ /

Licensed to Practice

32 List all states in which you are licensed to practice, primary practice state first. If temporary, submit a copy of your permit. *Please check the box to the far right if you plan to practice in that state in the next year.* ▼

State	License number	Date	Status *see below*◆	% of Practice	
State (primary practice)		/ /			☐
		/ /			☐
		/ /			☐
		/ /			☐

◆ Status is **Temporary** / **Active** / **Inactive** / **Suspended** / **Restricted** / **Revoked**
If anything other than Active, explain in notes. if more that four, list in 'notes' section.

Education

33-35

33

	City / State / Country	Date	
Medical school graduated		Graduation date / /	Degree
Internship hospital		Completion date / /	Type
Residency hospital		Completion date / /	Type
Residency hospital		Completion date / /	Type
Fellowship location		Completion date / /	Type

34 If you are a foreign medical graduate, are you certified by the Educational Council for Foreign Medical School Graduates? Yes ☐ No ☐

Insurance History

35 Insurance history for the preceding five (5) years, begin with current policy (Please indicate whether or not you purchased a tail, and attach a copy of your current declarations page): ▼

Company name	Policy type / Policy number / Liability limits	From	To	Tail bought
		/ /	/ /	Yes ☐ No ☐
		/ /	/ /	Yes ☐ No ☐
		/ /	/ /	Yes ☐ No ☐
		/ /	/ /	Yes ☐ No ☐
		/ /	/ /	Yes ☐ No ☐
		/ /	/ /	Yes ☐ No ☐

▼

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Medical Malpractice Insurance

36-41

Claims History

36 Are you now, or have you ever been involved, directly or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services? ▼ Yes ☐ No ☐

37 If "Yes", how many? ____

38 If "Yes", have these been reported to your insurer? Yes ☐ No ☐

39 Do you have knowledge of any claims, potential claims, or suits in which you may become involved, including without limitation, knowledge of any alleged injury arising out of the rendering or failing to render professional services which may give rise to a claim? Yes ☐ No ☐

If "Yes", have these been reported to your insurer? Yes ☐ No ☐

40 If you have answered "yes" to Question 36, 37, 38 or 39 above, are there any claims or suits or circumstances for which you answered yes that you have not reported to your current professional liability insurer? Yes ☐ No ☐

41 If you have answered "yes" to Question 36, 37, 38, 39 or 40 above, have you completed the attached claims form? Yes ☐ No ☐

Potential Liability

Please use the 'notes' section to explain in detail any "checked or Yes" responses for questions 42-45

42 Are you aware of any patient you have treated in the past 24 months who developed any of the following conditions during or after treatment that may have been caused by medical negligence?
Please check all that apply. ▼

☐ Brain injury

☐ Spinal cord injury and/or damage resulting in significant sensory and/or motor loss

☐ Serious burn injury

☐ Amputation of a significant portion of a limb(s)

☐ Birth trauma

☐ Paraplegia, quadriplegia, tetraplegia or other bodily paralysis

43 Are you aware of any patient you have treated in the past 36 months whose condition or treatment resulted in death that may have been caused by medical negligence? Yes ☐ No ☐

44 Are you aware of any patient you have not treated, but with whom you had a part in their care in the past 24 months by way of consultation, tests, reports, or other medical services who developed any of the following conditions during or after such medical care that may have been caused by medical negligence?
Please check all that apply. ▼

☐ Brain injury

☐ Spinal cord injury and/or damage resulting in significant sensory and/or motor loss

☐ Serious burn injury

☐ Amputation of a significant portion of a limb(s)

☐ Birth trauma

☐ Paraplegia, quadriplegia, tetraplegia or other bodily paralysis

45 Are you aware of any patient you have not treated, but with whom you had a part in their care in the past 36 months by way of consultation, tests, reports, or other medical services whose condition or treatment resulted in death that may have been caused by medical negligence? Yes ☐ No ☐

Reference

Make copies of this page as needed to provide required information

Notes

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Understanding, Authorization and Signature:

Important: This Application must be signed by the Applicant.

As a licensed physician or surgeon, the undersigned has made application for insurance to Missouri Doctors Mutual Insurance Company (MoDocs), and in connection with said Application has furnished the above information and the information in the 'notes' section attached.

I understand and agree this Application and any and all exhibits and attachments thereto will be made a part of any policy issued, and any such policy will be issued in reliance upon the representations made herein which are warranted to be true and complete. I further understand that these answers and statements are material and agree that failure to provide a true and complete response to the foregoing questions or to supplement as provided above may, at the option of MoDocs, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize MoDocs, through the Missouri Highway Patrol or any other agency, to conduct a criminal history file check or investigation by name and identifiers to determine the existence of any arrest resulting in conviction and furnish a response to MoDocs.

I authorize and consent to investigations of information bearing upon moral character, training, professional reputation, previous claims and suits, and fitness to engage in the activities authorized by my license to practice medicine, including, but not limited to, authorization to every person or entity, public or private, to release to MoDocs, any documents, records, or other information bearing upon the foregoing. I further authorize the use of a copy of this authorization in lieu of its original. I further authorize MoDocs to forward additional information to me by facsimile.

I understand and agree these investigations shall not be confined to information submitted in this Application, but shall include any other sources of information deemed relevant by MoDocs as may be authorized by law.

Signature

______________________	______________________	___/___/___
Signature in full of Applicant	Please PRINT Name of Signatory	Date

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Hospital Records Authorization and Signature:

Important: This Application must be signed by the Applicant.

As a licensed physician or surgeon, the undersigned has made application for insurance to Missouri Doctors Mutual Insurance Company (MoDocs) and in connection with said application has furnished this authorization for release of information.

I authorize any hospital at which I currently have privileges, or any hospital at which I have in the past had privileges, to release any and all records relating to my service at such hospital including, but not limited to, complaints of any nature, and the contents of my medical staff or peer review files.

I further authorize the use of a copy of this authorization in lieu of its original.

Signature

____________________	____________________	___/___/___
Signature in full of Applicant	Please PRINT Name of Signatory	Date

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Claim / Suit Questionnaire

Complete a copy of this page for each claim. Please type or print.

Claimant

Claimant's name(s)

Date of Birth	Sex	Date of alleged incident, error or act
/ /		/ /

Reported

Name of insurer to which claim was reported	Date report was made to insurance company
	/ /

Status

This matter is: ☐ Open ☐ Closed ▶	If matter is closed, date closed / /

☐ Incident report only ☐ Demand made ☐ Suit dismissed with prejudice

☐ Suit dismissed without prejudice ☐ Suit abandoned no activity from claimant for over 3 years ☐ Suit filed, judgment in your favor

	Total paid	Total paid on your behalf
☐ Suit settled ▶	$	$
☐ Jury verdict for plaintiff ▶	$	$

☐ Settlement is under consideration, complete the following: ▼

Offer	Demand	Insurer's loss reserve
$	$	$

Additional defendants

Description

Description of claim, include allegation, events leading up to claim, diagnosis and treatment, results of treatment, prognosis, and any other facts pertinent to the case. Continue on a separate sheet as needed.

I UNDERSTAND THAT THE REPRESENTATIONS PROVIDED HERE BECOME PART OF THIS APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE AND AFFIRM THAT NO MATERIAL FACTS HAVE BEEN SUPPRESSED OR MISSTATED.

Signature

Signature in full	Please PRINT Name of Signatory	Date / /