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RENEWAL APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE

Missouri Doctors Mutual Insurance Company (NAIC #11964)

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

MoDocs®

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 Personal

First name	Middle name	Last name	Suffix (Jr./Sr./III)

Policy number

2 Practice Profile

Type of practice (Check one):
☐ Private practice ☐ Urgent care center ☐ Other *specify*►

Practicing as (Check one) If you check corporation or partnership or employed physician, please complete information below
☐ Individual ☐ Corporation ▼ ☐ Partnership ▼ ☐ Employed physician ▼

3 Practice Address

If Changed Since Original Application

Entity (Corp, LLC, etc.) as registered on the Secretary of State website to include doing business as.

Practice name

Street | Suite

City | State | Zip | County

Office phone ( ) - | Office fax ( ) - | Office email

Contact person | Number of practice locations (If different from # 3 list on notes page)

4 Practice Profile

Paramedical Personnel Census

In the blank space provided enter the number of personnel employed.

◆ *Attach a copy of the collaborative agreement for these specialties.*

If you or your partnership or corporation will employ any paramedical personnel, please provide the census information requested below. If you are practicing as part of a group practice, only one individual (i.e.Corporate Officer or Partner) is required to complete this section on the master application if the information applies to all in the group. ▼

_____ Anesthesiologist Assistant◆	_____ Nurse practitioners◆	_____ Physician assistant◆
_____ Certified nurse midwives	_____ Nurses—LPN	_____ Psychologists
_____ Licensed Clinical Social Worker	_____ Nurses—RN	_____ Other
_____ Nurse anesthetists—CRNA's	_____ Optometrists	

Professional Profile...

5 Primary specialty	% of Practice	Years practicing primary specialty

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

7 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 ☐

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Professional Profile...

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

8 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 ☐

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

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

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

12 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 ☐

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

14 Do you or does your business entity own, operate, manage or participate in any medical enterprise or business? (If yes, please describe in the 'notes' section) Yes ☐ No ☐

15 Have you ever signed any contractual agreement in which you have agreed to indemnify (hold harmless) other persons or entities? Yes ☐ No ☐

16 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 ☐

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

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

19 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 ☐

20 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? _____

21 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 ☐

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

☐ Hospital ☐ Non-hospital facility ☐ Office

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

24 Do you perform obstetrical procedures? Yes ☐ No ☐

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

☐ Elective ☐ Emergency

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

☐ First trimester ☐ Second trimester ☐ Third trimester

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

Hours per month? _____

28 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 ☐

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Professional Profile
continued…

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

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

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

31 Do you prescribe pain management medications? *If "yes", explain in 'notes' section.* Yes ☐ No ☐

32 Do you provide addiction treatment or services (including, but not limited to: prescription of addiction medications, counseling, etc.)? *If "yes", explain in 'notes' section.* Yes ☐ No ☐

Procedures Profile

33 Please check any of the following procedures you perform or any of the agents you use. Provide any details you consider relevant in the 'notes' section. ▼

☐ Abdominoplasty	☐ Bone grafts	☐ Colporrhaphy and perineoplasty
☐ Abortions, therapeutic	☐ Botox Injections	☐ Conization (hot and cold knife)
☐ Acupuncture	☐ Breast augmentation, cosmetic	☐ Conization of cervix
☐ Amniocentesis	☐ Breast augmentation, resconstructive	☐ Corneal transplant
☐ Anal Fissurectomy	☐ Capsulorrhaphy	☐ Coronary stent placement
☐ Anesthesia, general	☐ Capsulotomy	☐ Cosmetic plastic surgery
☐ Anesthesia, IV analgesia (surgical)	☐ Cardiac catheterization, left heart	☐ Cricothyrotomy
☐ Anesthesia, spinal	☐ Cardiac catheterization, right (swan ganz)	☐ Cryosurgery
☐ Angiography, all others	☐ Cardioversions	☐ Culdocentesis
☐ Angiography, cerebral or coronary	☐ Carpal tunnel surgery	☐ Dacryocystotomy
☐ Angioscopy	☐ Cataract surgery	☐ Defibrillation
☐ Appendectomy	☐ Cervical diskectomy	☐ Dermabrasion
☐ Arterial and venous lines	☐ Cervical laminectomy	☐ Dilation and curettage
☐ Arterial bypass	☐ Chalazion excision from eyelids	☐ Dilation and evacuation
☐ Arthroscopy	☐ Cheiloplasty	☐ Ectopic pregnancy
☐ Atherectomy / rotation ablation	☐ Chemical face peel	☐ Electroconvulsive therapy (ECT)
☐ Autologous fat Injection, penis	☐ Cholecystectomy	☐ Electromyography
☐ Automated lamellar keratoplasty (ALK)	☐ Chorionic gonadotropin for obesity	☐ Endometrial biopsy
☐ Balloon valvuloplasty	☐ Chymopapain disc Injection	☐ Endoscopy: ▼
☐ Bariatric surgery	☐ Circumcision, adult	
☐ Biopsy: ▼	☐ Circumcision, pediatric	☐ ENT surgery
☐ Blepharoplasty, cosmetic	☐ CO2 laser	☐ Enucleation
☐ Blepharoplasty, functional	☐ Cobalt therapy	☐ Episiotomy
☐ Blocks, spine	☐ Collagen Injections	☐ Esophageal dilation

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Procedures Profile
continued…

- ☐ Excision of breast tumor
- ☐ Facet injections
- ☐ Facial Lifts
- ☐ Fallopian tube removal
- ☐ Fine needle aspiration
- ☐ Fine needle biopsy
- ☐ Fistula repair
- ☐ Forehead lifts
- ☐ Foreign body removal
- ☐ Fracture reduction, closed, other than simple
- ☐ Fracture reduction, closed, simple
- ☐ Fracture reduction, open
- ☐ Frenotomy
- ☐ Gastric lavage
- ☐ Gastric or ileal bypass for obesity
- ☐ Gastric sleeve or bubble for obesity
- ☐ Glaucoma procedures
- ☐ Glycolic peels
- ☐ Hair transplant
- ☐ Hand surgery
- ☐ Heart biopsy
- ☐ Hemorrhoidectomy, ligation only
- ☐ Hemorrhoidectomy, other than ligation
- ☐ Herniorrhaphy
- ☐ Human growth hormone
- ☐ Hydrocelectomy
- ☐ Hymenectomy
- ☐ Hymenotomy
- ☐ Hypophysectomy
- ☐ Hysterectomy, abdominal
- ☐ Hysterectomy, vaginal
- ☐ In vitro fertilization (IVF)
- ☐ Independent medical evaluations
- ☐ Intrabulbar masses
- ☐ Intraocular lens implants
- ☐ Intubation
- ☐ Iridectomy
- ☐ Joint Injection and intra-articular blocks
- ☐ Joint replacement
- ☐ Laparoscopy
- ☐ Laryngography / laryngoscopy
- ☐ Laser hair removal
- ☐ Laser skin resurfacing
- ☐ Laser surgery
- ☐ LASIK
- ☐ Leeps / leetz procedure
- ☐ Lid repair
- ☐ Liposuction surgery
- ☐ Lumbar laminectomy
- ☐ Lumbar puncture
- ☐ Lumpectomy, other
- ☐ Lumpectomy, superficial skin lesion
- ☐ Lymph gland biopsy
- ☐ Lymphangiography
- ☐ Manipulation under anesthesia
- ☐ Mentoplasty
- ☐ Microsurgery
- ☐ Mohs' chemosurgery
- ☐ Myelogram / myelography
- ☐ Myringotomy
- ☐ Nasal polypectomy
- ☐ Nasopharyngeal surgery
- ☐ Needle aspiration
- ☐ Neonatal intensive care
- ☐ Nerve repairs
- ☐ Nerve root injections
- ☐ Obstetrical procedures, birthing center
- ☐ Obstetrical procedures, home or other
- ☐ Obstetrical procedures, hospital
- ☐ Obstetrics, deliveries, high risk
- ☐ Obstetrics, deliveries, routine
- ☐ Oophorectomy
- ☐ Orbital bone fracture repairs
- ☐ Orchidectomy
- ☐ Osteopuncture
- ☐ Otoplasty
- ☐ Pacemakers (temporary/ permanent)
- ☐ Pain control / management, medication only
- ☐ Paracentesis
- ☐ Parotidectomy
- ☐ Penile implants
- ☐ Percutaneous endoscopic Gastrostomy
- ☐ Pericardiocentesis
- ☐ Perineal repair
- ☐ Perineorrhaphy
- ☐ Peripheral nerve blocks
- ☐ Permanent lash liner
- ☐ Phlebography
- ☐ Photorefractive keratotomy (PRK)
- ☐ Phototherapeutic keratotomy (PTK)
- ☐ Pleural biopsy, closed
- ☐ Pleural biopsy, open
- ☐ Polypectomy by endoscopy

Procedures Profile
continued…

- ☐ Prenatal care
- ☐ Prolotherapy
- ☐ Pterygium excision
- ☐ Radial keratotomy
- ☐ Radiation therapy
- ☐ Radical neck dissection
- ☐ Radioactive implants
- ☐ Rapid detoxification
- ☐ Rectocele
- ☐ Retinal detachment repair
- ☐ Retrobulbar blocks
- ☐ Rhinoplasty, cosmetic
- ☐ Rhinoplasty, functional only
- ☐ Rhytidectomy
- ☐ Sacroiliac joint blocks
- ☐ Salivary gland surgery
- ☐ Salpingectomy
- ☐ Scalene node biopsy
- ☐ Sclerotherapy
- ☐ Selective nerve root blocks
- ☐ Septorhinoplasty
- ☐ Sex change (transsexual) surgery
- ☐ Small bowel biopsy
- ☐ Sphincterectomy
- ☐ Spinal infusion pump implantation
- ☐ Spinal surgery
- ☐ Sympathectomy
- ☐ Tendon repair
- ☐ Tenotomy
- ☐ Therapeutic radiology
- ☐ Thyroid Surgery
- ☐ Tissue expansion
- ☐ Tonsillectomy
- ☐ Tonsilloadenoidectomy (T & A)
- ☐ Trabeculectomy
- ☐ Tracheostomy
- ☐ Tubal ligation
- ☐ Tympanostomy
- ☐ Ultrasound
- ☐ Uterine suspension
- ☐ Valvuloplasty
- ☐ Vasectomy
- ☐ Vein stripping
- ☐ Venography
- ☐ Ventricular shunt
- ☐ Vertebroplasty
- ☐ Weight control, medications: ▼
- ☐ Wound debridement

Professional Duties

34 Estimate the total number of hours you work per week in office and clinical practice including direct patient care, consultation, administrative activities, etc. — Hours per week

35 Do you provide medical information or advice, interpret files, prescribe medication, or sell any products or services via the internet or other telecommunications system? Yes ☐ No ☐

Medical Malpractice Insurance

36 Are you aware of any circumstances which may result in a malpractice claim or suit being presented against you? *If "yes", explain in 'notes' section.* Yes ☐ No ☐

37 Are you aware of any circumstances which may result in a malpractice claim or suit being presented against any of your partners, members of your professional association or corporation, or your employees? *If "yes", explain in 'notes' section.* Yes ☐ No ☐

38 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.*** ▼

Potential Liability

- ☐ 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

Please use the 'notes' section to explain in detail any "checked or Yes" responses for questions 36-41. ▼

39 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 ☐

Medical Malpractice Insurance

continued…

Please use the 'notes' section to explain in detail any "checked or Yes" responses for questions 36-41.

40 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

41 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 ☐

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 MoDocs, or any third party, to obtain and/or run a personal credit report on myself and a business credit report on my medical practice/clinic.

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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