Nurse Anesthetist
Application for Professional Liability Insurance
Additional Insured Basis

To be completed by nurse anesthetist:

1. Policyholder's Name _____ 2. Policy number _____

3. Your Full Name _____ 4. Date of Birth (mm/dd/yyyy) _____

5. Type of association: ☐ W2 Employee ☐ 1099 Independent Contractor ☐ Other (Specify)_____

6. Your E-mail _____

7. Your License # (in state where you will practice) _____ (attach a copy) State _____

8. Desired Effective Date _____ 9. Number of hours per week worked _____

10. School Attended _____ ☐ Attachment contains this information From (mm/yyyy) _____ To (mm/yyyy) _____

11. Please indicate any previous employment as a Nurse Anesthetist. ☐ Attachment contains this information

Name	From:	To:

_____ ☐ None

12. Your Current (or most recent) Insurance Carrier

a) Limits of Liability	b) Policy Number	c) Expiration Date

If currently insured, does your carrier cover you for your work with the MIEC insured listed in question #1? ☐Yes ☐No

If yes, provide a copy of your current Certificate of Insurance.

13. Have you <u>ever</u> been notified of your involvement in a malpractice claim, suit or incident, either directly or indirectly? ☐Yes ☐No

If yes, you must complete a Claim Information Form for each. (see page 4)

14. Are you applying for hospital privileges? ☐Yes ☐No

If yes, please list names and locations of hospitals in the Additional Comments section.

15. Have you ever been charged with or been convicted of a felony? ☐Yes ☐No

16. Have you ever been convicted of or entered a "no contest" plea to a crime, other than a traffic violation? ☐Yes ☐No

17. Have you ever been investigated by a state or federal regulatory body? ☐Yes ☐No

18. Has any governmental agency ever suspended, revoked, restricted, placed you on probation, or taken any other action against your license? ☐Yes ☐No

19. Have you ever been diagnosed as having or been treated for alcoholism, narcotics addiction or mental illness? ☐Yes ☐No

20. Has any insurance carrier ever declined, canceled, refused to renew, restricted or rated up your professional liability insurance? ☐Yes ☐No

21. Have you ever had any hospital privileges suspended, revoked, restricted, reduced, proctored or modified in any way? ☐Yes ☐No

If you answered "Yes" to any of Questions 15-21, provide full details on separate attachment or in the Additional Comments section below.

ADDITIONAL COMMENTS

The undersigned hereby represents that all statements and answers in this application are true and complete and that no information which is calculated to influence the judgment of the company in considering this application has been withheld.

I authorize the release to MIEC of information regarding past and pending claims and underwriting matters from my professional liability insurance carriers, or from my past and present medical association or society. I further agree that the organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information.

_____ _____

Signature Date

_____ _____

Print Name Phone Number

_____

Address

MIEC ANESTHESIOLOGY RESTRICTIVE ENDORSEMENT

(Certified Registered Nurse Anesthetist)

MIEC agrees with you that neither defense nor indemnity insurance coverage is available under Parts I or II of the COVERAGE PROVISIONS of this policy for claims, civil lawsuits, arbitrations, legal or administrative proceedings, incidents, accidents, or events resulting from the administration of regional or general anesthesia by any certified registered nurse anesthetist (CRNA) who is an insured unless:

1. Except as provided in paragraphs 3, 5 and 6 below, such CRNA shall be physically present in the operating room at all times during the course of such regional and general anesthesia, provided, however, that in the event such CRNA is required to leave the operating room during the course of such regional or general anesthesia, a physician or nurse trained in anesthesiology shall replace such CRNA and shall remain in the operating room at all times during such absence.
2. In the event of a bona fide emergency requiring the temporary absence of such CRNA and a physician or nurse trained in anesthesiology is not available, a physician trained in advanced cardiopulmonary life support and a trained licensed nurse may replace such CRNA only if (1) the condition of the patient is stable and (2) the replacements remain in the operating room and monitor the patient at all times during such absence.
3. Except as provided in paragraphs 5 and 6 below, the following means of monitoring shall be mandatory during the course of such regional and general anesthesia, including anesthesia for cesarean section, at whatever location in the facility. Blood pressure and heart rate should be recorded every five minutes; respiratory rate and oximeter reading every 15 minutes; carbon dioxide recordings every 15 minutes only if the endotracheal tube is placed.
   (a) Use of continual blood pressure monitoring with appropriate equipment which will give at a minimum periodic checks at regular intervals;
   (b) Use of continuous electrocardiographic display;
   (c) Use of an oximeter (reflective or transmissive);
   (d) Use of end tidal carbon dioxide monitor when an endotracheal tube is in place. A transcutaneous CO_2 monitor may be used instead of end tidal CO_2 monitor in small infants.
4. Except as provided in paragraphs 5 and 6 below, the following equipment shall be available during the course of regional or general anesthesia:
   (a) Equipment to measure temperature;
   (b) An audible device that detects disconnection of any component of the breathing system when an automatic ventilator is used;
   (c) An oxygen analyzer that will detect the concentration of oxygen and has a low concentration of oxygen alarm.
5. During the course of regional analgesia for pain during childbirth (other than birth by cesarean section), such CRNA shall remain with the patient until vital signs are stable; if such CRNA leaves the presence of the patient during the course of such regional analgesia, the patient must be observed at regular intervals by another certified registered nurse anesthetist or a licensed trained and competent obstetrical nurse.
6. During the course of regional analgesia for pain during childbirth (other than for cesarean section) such CRNA shall remain available on call in the hospital unless replaced by a physician trained in anesthesiology.
7. A complete record of anesthesia shall be maintained by the CRNA which shall contain periodic entries of all monitoring data.

This restrictive endorsement shall apply during the term of this policy or any renewal thereof, unless this restriction is removed by endorsement to the policy.

I have read and understand this endorsement and agree to leave it attached to and made part of my MIEC policy.

Signature _____ Date_____

CLAIM INFORMATION FORM

☐Attachment contains this information ☐ None [Please be sure to check here if no claims]

_____ _____ _____

Last Name of Patient/Claimant Gender Age

1. Condition and diagnosis of patient prior to treatment and/or surgery:

_____

_____

2. Date(s) and type of treatment and/or surgery rendered by you:

_____

_____

3. Condition of patient subsequent to treatment and/or surgery by you:

_____

_____

4. Nature of allegation:

_____

5. Was a suit ever filed against you? ☐Yes ☐No

If yes, was it served? ☐Yes ☐No

When? _____

6. Names of other doctors and hospital, if any, involved:

_____

_____

7. Disposition or current status. If settled or tried to plaintiff verdict, give amounts and dates:

_____

_____

_____ _____

Name of insurance carrier defending you Name of attorney defending you

PLEASE COMPLETE A CLAIM INFORMATION FORM FOR EACH PROFESSIONAL LIABILITY CLAIM, SUIT, INCIDENT OR ARBITRATION PROCEEDING, PAST OR PENDING, IN WHICH YOU HAVE BEEN INVOLVED DIRECTLY OR INDIRECTLY.

PRINT ADDITIONAL COPIES AS NEEDED.

You can send in your application by:

1. Mail – [Print PRE-PAID Mailing Label below]
2. Fax – (510) 318-6700
3. E-mail – Underwriting@MIEC.com

NO POSTAGE
NECESSARY
IF MAILED
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BUSINESS REPLY MAIL
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Medical Insurance Exchange of California
PO BOX 22777
Oakland, CA 94609-9930

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