

Non-Physician Healthcare Provider Application

1. Name of Employer _____ 2. Policy Number _____
3. Number of hours per week worked for above employer _____ 4. Desired effective date of coverage _____
5. Your Full Name _____ 6. Date of Birth _____
(mm/dd/yyyy)
7. Your E-mail _____

8. Professional Designation:
 Aesthetician Podiatrist
 Certified Nurse Midwife Psychologist
 Marriage, Family Therapist/Counselor Scrub Nurse/Technician
 Physical Therapist Social Worker
 Other _____

Attachment contains this information

9. School Attended _____ From _____ To _____

Attachment contains this information

10. Additional Training _____ From _____ To _____

11. Have you taken the exams for certification or licensure? Yes No
Oral examination? Yes No Date of exam _____ Pass Fail
Written examination? Yes No Date of exam _____ Pass Fail
Licensure Number _____

Attachment contains this information

12. Describe previous practice (Name of employer/solo practice) _____
Name _____ From _____ To _____
Name _____ From _____ To _____
Name _____ From _____ To _____
Name _____ From _____ To _____

13. Do you have professional liability insurance? Yes No If yes:
Name of Carrier _____ Policy No. _____ Expiration Date _____
Limits of Liability _____

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.

14. Have you ever been involved in a malpractice claim/suit? Yes No
If yes, you must complete a Claim Information Form for each. See page 3.
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 any 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 or narcotics addiction? Yes No
20. Are you being treated for any medical condition, disease or illness that affects your ability to provide care or treatment? Yes No
21. Has any insurance carrier **ever** declined, canceled, refused to renew, restricted, or surcharged your professional insurance? Yes No
22. What type of patients will you treat? _____

23. What procedures will you perform? _____

24. What therapies, lab work, and diagnostic studies can you order? _____
25. Describe the physician's supervisory responsibilities. _____

26. If not in the office, will the supervising physician be telephonically or electronically available to you? Yes No
If yes, please describe: _____

27. Under what circumstances will the supervising physician examine your patients? _____
28. How often will the physician review your charts? _____

- Note: SUBMIT 1) Curriculum vitae (CV)
2) Copy of license
3) Copy of individual insurance, if applicable

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

ADDITIONAL COMMENTS

The undersigned hereby represents that the above statements and answers 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 _____

CLAIM INFORMATION FORM

Attachment contains this information

None [Please be sure to check here if no claims]

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.