

Nurse Practitioner/Physician Assistant Questionnaire

Name of Employer _____ Policy Number _____

Number of hours per week worked for above employer _____ Desired effective date of coverage _____

Nurse Practitioner

Physician Assistant

This section to be completed by Nurse Practitioner or Physician Assistant

1. Your Full Name _____ 2. Date of birth _____
(mm/dd/yyyy)

3. Are you a licensed Registered Nurse? Yes No

(a) Nursing school attended _____ Year graduated _____

(b) License number _____ State _____ Expires _____

4. Additional training for Nurse Practitioner/Physician Assistant qualifications:

Name of school or facility _____ Certificate or advanced degree: From _____ To _____

5. Have you taken the National Physician Assistant Certifying Exam? Yes No If yes, please submit copy of certificate.

Are you licensed? Yes No If yes, Number _____ State _____ Expires _____

6. Are you registered with the Board of Registered Nurses as a Nurse Practitioner? Yes No

7. Are you applying for hospital privileges? Yes No If yes, please list names of hospitals and privileges granted.

8. Do you provide care in a nursing home? Yes No Name(s) of nursing home(s) _____

9. Do you provide home health care? Yes No Name of employer _____

10. Indicate previous employment as a Nurse Practitioner/Physician Assistant (give employer's name and address).

_____ From _____ To _____

_____ From _____ To _____

_____ From _____ To _____

11. Do you have professional liability insurance? Yes No 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 above? Yes No

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

12. Have you ever been involved in a malpractice claim or suit? Yes No

If yes, you must complete a claim information form for each (see page 4).

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

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

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

16. Has any governmental agency ever suspended, revoked, restricted, placed you on probation, or taken any other action against your license? Yes No
17. Have you ever been diagnosed as having or been treated for alcoholism, narcotics addiction or mental illness? Yes No
18. Has any insurance carrier ever declined, canceled, refused to renew, restricted or rated up your professional liability insurance? Yes No
19. 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 questions 13-19, provide full details, including dates, on separate attachment or in the Additional Comments section on page 3.

Signature _____ Date _____

This section to be completed by Supervising or Employing Physician

1. Name _____, MD/DO Telephone number _____
 Address _____
 _____ City _____ State _____ Zip Code _____

2. Will patients be given an option to be treated by a physician or a non-physician clinician? Yes No

3. What type of patients will the NP/PA treat? _____

4. Will NP/PA practice only at the above address? Yes No
 If no, please explain. _____

5. What percentage of patients seen by NP/PA will be seen by you as a matter of routine? _____

6. Will NP/PA be authorized to dispense and/or prescribe drugs? Yes No
 If yes, please provide a copy of your written medication protocols.
 (a) When will charts of patients, for whom prescription drugs have been ordered, be reviewed and initialed by you? _____

 (b) How often will other charts be reviewed by you? _____

7. What therapies, lab work, and diagnostic studies can the NP/PA order? _____

8. What procedures can the NP/PA perform? _____

9. How often will you review the NP's/PA's charts to assess completeness of documentation and quality of care rendered? _____
 Although you may not be required to review or cosign an NP's charts, we recommend that our policyholders do so.

10. Under what circumstances will you examine the NP/PA's patients? _____

11. Will the NP/PA collaborate with you prior to referring patients to a consultant? Yes No

12. Describe your supervisory responsibilities for the NP/PA. _____

13. If not in the office, will you be telephonically or electronically available to the NP/PA? Yes No
If yes, describe _____

14. Will NP/PA assist in any surgical procedures? Yes No
If yes, please explain. _____

Signature _____ Date _____

ADDITIONAL COMMENTS

Submitted by: NP/PA MD/DO

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.