Nurse Practitioner
Application for Professional Liability Insurance
Additional Insured Basis*

IMPORTANT INSTRUCTIONS – PLEASE READ CAREFULLY

**Coverage on an Additional Insured Basis provides coverage only while working within the course and scope of the employment/independent contractor agreement with the MIEC policyholder identified in this application.*

- COMPLETE ALL QUESTIONS: A complete application will allow us to process your application as quickly as possible. Please note the first portion of the application is for completion by the applicant and the second portion of the application is for completion by the supervising/collaborating physician.

- REQUIRED ATTACHMENTS: In addition to completing all questions provide the following attachments:
  - Collaborative Plan
  - Standardized Procedures or Protocol
  - Medication Protocols (if dispensing and/or prescribe drugs)
  - Current Curriculum Vitae
  - Employment or Independent Contractor Agreement – if applicable

- ADDITIONAL COMMENTS: If you wish to provide detailed responses to any of the questions in the application, please use the "Additional Comments" section on page 4 of the application.

MIEC acknowledges that requirements imposed by this application may exceed requirements imposed by law or standards of professional practice, but believes that such requirements are reasonable.

For assistance, you may call our main office at the number below from 8:00 a.m. to 5:00 p.m. PST or E-mail us at the address below. Please include in your E-mail the location of your practice including the city and state.

800-227-4527
(510) 428-9411
FAX: (510) 318-6700
E-MAIL: UNDERWRITING@MIEC.COM

Nurse Practitioner
Application for Professional Liability Insurance
Additional Insured Basis

MIEC Policyholder Name _____ Policy Number _____

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

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

This section to be completed by Nurse Practitioner

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

2. Are you a Registered Nurse? ☐Yes ☐No

   (a) Nursing school attended _____ Year Graduated _____

   (b) License Number _____ State _____ Expires _____

3. Additional training for Nurse Practitioner qualifications:

   Name of school or facility _____ Certificate or Advanced Degree _____ From _____ To _____

Type of Program (check one): __General Acute Care __Adult __ Adult Psychiatric and Mental Health __Family __ Family Psychiatric and Mental Health __Pediatric __Women's Health __Other (specify): _____

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

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

   _____

   _____

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

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

8. Indicate previous service as a Nurse Practitioner (give physician or medical group name and address).

   _____ From _____ To _____

   _____ From _____ To _____

   _____ From _____ To _____

9. Indicate outside work as a Nurse Practitioner.

   _____ Start Date _____

   _____ Start Date _____

10. 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.

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11. 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 5).

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

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

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

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

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

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

18. 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 11-18, provide full details, including dates, on separate attachment or in the Additional Comments section on page 4.

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

This section to be completed by Supervising or Employing Physician

1. Name _____, MD/DO 2. Telephone Number _____

   Address _____ City _____ State _____ Zip Code _____

2. Will patients be given an option to be treated by a physician? ☐Yes ☐No

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

4. Will the NP practice only at the above address? ☐Yes ☐No

   If no, please explain _____

   _____

5. What percentage of your time will the NP and you be together at the same practice location? _____

6. What percentage of patients seen by the NP will be seen by you as a matter of routine? _____

7. Will NP be authorized to dispense and/or prescribe drugs? ☐Yes ☐No

   (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? _____

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8. What therapies, lab work, and diagnostic studies can the NP order? _____

_____

9. What procedures can the NP perform?_____

_____

_____

10. How often will you review the NP'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.

11. Under what circumstances will you examine the NP's patients? _____

12. Will the NP collaborate with you prior to referring patients to a consultant? ☐Yes ☐No

13. Describe your supervisory responsibilities for the NP: _____

_____

_____

14. If not in the office, will you be telephonically or electronically available to the NP? ☐Yes ☐No

If yes, describe _____

15. Will NP assist in any surgical procedures? ☐Yes ☐No

If yes, please explain._____

_____

I authorize the applicant to be endorsed under the above policy.

_____ _____

Signature of Physician/Authorized Representative Date

ADDITIONAL COMMENTS

Submitted by: NP ☐ MD/DO ☐ OTHER ☐

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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 healthcare providers 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.

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