Physician Assistant
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 NP/PA applicant and the second portion of the application is for completion by the supervising or employing physician.

- **REQUIRED ATTACHMENTS**: In addition to completing all questions provide the following attachments:
  - Delegation of Services Agreement
  - Standardized Procedures or Protocol
  - Medication Protocols (if applicant will dispense and/or prescribe drugs)
  - Current Curriculum Vitae
  - Employment / 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

Physician Assistant
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 Physician Assistant

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

2 Additional training qualifications:

   Name of school or facility ______________ Certificate or Advanced Degree ________ From ______ To _____

3. 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 ______

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

   ____

   ____

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

6. Do you provide home health care? ☐Yes ☐No Name of employer ______________________________

7. Indicate previous service as a Physician Assistant (give physician or medical group name and address).

   ____ From ______ To _____

   ____ From ______ To _____

   ____ From ______ To _____

8. Indicate outside work as a Physician Assistant.

   ____ Start Date __________

   ____ Start Date __________

9. 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.

10. 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).

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

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

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

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

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

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

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17. 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 10-17, 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 Collaborating Physician

☐ See Delegation of Services Agreement and Scope of Practice
If you have not developed a Delegations of Services Agreement, please answer the following questions.

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 PA treat? ______________________________

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

   If no, please explain ______________________________

   ____

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

6. What percentage of patients seen by PA will be seen by you as a matter of routine? ______________

7. Will PA 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? ______________________________

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

   ____

9. What procedures can the PA perform?

   ____

   ____

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10. How often will you review the PA's charts to assess completeness of documentation and quality of care rendered? ___________________________

11. Under what circumstances will you examine the PA's patients? ____

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

13. Describe your supervisory responsibilities for the PA:____

____

____

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

If yes, describe ____

15. Will the PA 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: PA ☐ 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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