

**Professional Liability Application for  
MEDICAL DIRECTOR'S PROFESSIONAL LIABILITY INSURANCE**

**GENERAL INFORMATION**

1. Physician Applicant Name:
2. Address:
3. Telephone Number: Office Fax
4. Type of organization, service or facility where applicant provides services as Medical Director
  
5. Name of organization:
6. Address:
7. Telephone Number: Office Fax
8. Extent of operations (size) of organization, service or facility, for which these units of exposure are applicable:  

No. of beds	No. of Out Patient Visits	No. of Ambulances
Organization / service / facility's annual receipts (or operating budget): \$		
9. Medical Director Duties / Contract: **attach copy of contract between Medical Director & organization, and description of the duties and responsibilities of medical director, if not included in contract.**
10. Describe any circumstances wherein the applicant in his/her capacity as Medical Director may also be called upon to act with his/her capacity as a 11physician7 to treat, intervene in the treatment, direct the treatment or consult in the treatment of any person (patient / client):  
  

How often might such circumstances occur?
11. Time commitment - number of hours per month applicant with provide services as Medical Director:
12. Remuneration - annual remuneration applicant will be paid for service as Medical Director: \$
13. LIMIT OF LIABILITY requested: \$ per incident / \$ per aggregate
14. PROPOSED EFFECTIVE DATE: No. Years as Medical Director

**APPLICANT PHYSICIAN INFORMATION**

15. License # Expiration Date State Years licensed  
 Certification:
16. Current Practice: (dates from to )  
 Specialty: Board Certified?  
 Type Practice: Solo Practice Partnership Group Practice Other:  
 Prior Practice: (dates from to )

**NOTICE**

THIS POLICY (IF ISSUED) IS ISSUED BY YOUR RISK RETENTION GROUP. YOUR RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL THE INSURANCE LAWS AND REGULATIONS OF YOUR STATE. STATE INSURANCE INSOLVENCY GUARANTY FUNDS ARE NOT AVAILABLE FOR YOUR RISK RETENTION GROUP.

17. Medical School Date completed: Degree:
18. Internship / Residencies:

- Medical Center: \_\_\_\_\_ dates served: \_\_\_\_\_ to \_\_\_\_\_  
 Medical Center: \_\_\_\_\_ dates served: \_\_\_\_\_ to \_\_\_\_\_
19. Hospital Privileges (hospital name / address & nature of privileges): \_\_\_\_\_
20. Medical Malpractice Insurance - **attach certificate or other verification of current insurance.**
21. Claims Information: Has any claim or suit for alleged malpractice been brought against you in the last 5 years, or are you aware of circumstances that might lead to such a claim/suit?    Yes    No  
 If Yes, describe event including claimant name, date of incident, suit status, amount of settlement or reserve (or attach separate sheet): \_\_\_\_\_
22. Sanctions: Has applicant ever had his/her license or certification revoked, suspended, or restricted, been subject to any disciplinary proceeding, been reprimanded by an administrative agency, professional association or peer committee:    Yes    No If Yes, describe in detail: \_\_\_\_\_

**STATEMENT OF NON-CONFLICT OF RELATIONSHIP:**

1. Applicant is NOT a principal, proprietor, superintendent, officer director, stockholder or member of the board of directors, trustees, or governors, of the organization named in Item 5 of this application, nor is applicant in any other manor, except as Medical Director, affiliated or associated with said organization.
- It No patient or client of the organization named in Item 5 of this application is (will be) billed or charged specifically for services afforded by the applicant whether in his/her capacity as Medical Director, physician or otherwise.
- EXCEPTIONS, if any, to above (absence of entry means "no exceptions"):

**I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.**

**I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Mid-Century General Agency, Inc. any documents, records or other information bearing upon the foregoing.**

**I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.**

**Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.**

**IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.**

Date

\_\_\_\_\_  
 Applicant

# Supplementary Page

Please reference the number of the question to which these responses apply.