

MEDICAL PRACTITIONERS APPLICATION CLAIMS-MADE COVERAGE

PHYSICIANS' ALTERNATIVE SOLUTIONS - NONSTANDARD PHYSICIANS RENEWAL APPLICATION

Carefully read this page and the questions posed in this application. In order for you to be considered for coverage, this application must be completed in full and submitted along with required attachments and/or supplementary information requested throughout the application. ***In order to expedite the underwriting process, please write legibly and ensure that all questions have been fully answered.*** Additional information may be required upon review of the application. If the application does not provide you with sufficient space to properly respond to a question, please write "see attached" and respond via separate attachment. Please be sure to sign and date the attachment.

➤ **The following required attachments must be submitted along with the fully completed RENEWAL APPLICATION.**

- ☐ Curriculum Vitae/Resume and letterhead **IF CHANGED IN THE PAST 12 MONTHS.**
- ☐ Formal, up-to-date loss runs from a prior insurance company **IF ANY OF THE FOLLOWING STATEMENTS APPLY:**
- There was an open claim, suit or incident pending with the prior carrier at last year's anniversary;
 - An Extended Reporting Period (ERP) Endorsement was purchased from the insurance carrier within the past 5 years;
 - Coverage was written on an occurrence basis by the insurance carrier within the past 5 years.
- ☐ A **CLAIM SUPPLEMENTAL FORM** or comprehensive narrative on your letterhead must be completed for each claim resolved/closed or new claim made, incident surfacing and/or suit brought against you **IN THE PAST 12 MONTHS THAT HAS NOT ALREADY BEEN REPORTED TO CNA.**

➤ **Please contact your insurance agent if you have any questions concerning this application or the coverage for which this application applies.**

NOTE: This is an application for insurance, not an insurance binder. Your application is subject to underwriting review and approval by the company. The effective date, prior acts date (aka retroactive date or nose coverage), and additional classification and/or rating aspects of this application are also subject to approval by the company. No offer of coverage exists unless and until this application is accepted/approved by the company, **and**, you have received written notification of said acceptance.

I. PERSONAL/PROFESSIONAL DATA

Name (last, first, middle)				Designation ☐ MD ☐ DO	
Business/Entity Name					
IN THE PAST 12 MONTHS , has there been any change in your practice structure or ownership (solo practitioner, solo incorporated group practice, employee, etc.)? ☐ No ☐ Yes					
Current CNA Policy Number: NSD- _____				Social Security Number: _____	
Primary practice address	City	State	Zip Code	County	
Residence address	City	State	Zip Code	County	
Office telephone	Office fax			Residence telephone	
Do you have any other Practice Locations? If "Yes", please list: ☐ No ☐ Yes				Email	

II. MEDICAL SPECIALTY, TRAINING AND LICENSE HISTORY

Please answer all questions completely. If a question does not apply to you, mark "N/A" or "0." Do not leave any questions unanswered. If space is inadequate, use the space provided under Section V. Comments or use your letterhead.

1. Medical specialty: _____ Percentage of practice: _____ %

Sub-specialty: _____ Percentage of practice: _____ %

A. Do you limit your practice to the above Specialty and/or Sub-specialty? ☐ No ☐ Yes

IF NO, please explain: _____

B. Have you added or discontinued procedures which are considered to be outside of, or not usual to the above practice specialty, or are experimental in nature within the past year or do you anticipate doing so in the near future? ☐ No ☐ Yes

IF YES, please list procedures/services and note dates of change(s):

C. Have you changed your medical specialty within the past year or do you anticipate doing so in the near future? ☐ No ☐ Yes

IF YES, please provide complete details and note dates of change(s):

2. Number of hours continuing education completed within the past two years: _____ hrs.

3. Please list your Medical Licenses including all active and inactive and your Narcotics/DEA License:

State	License number	Expiration date	Status

Narcotics/DEA License: _____ Status: _____

IN THE PAST 12 MONTHS:

- a. Has any State/Medical Board refused you a medical license? ☐ No ☐ Yes
- b. Has any State/Medical Board restricted, suspended or revoked your medical license? ☐ No ☐ Yes
- c. Has any State/Medical Board imposed a fine or any other obligation? ☐ No ☐ Yes
- d. Has any State/Medical Board issued a letter of guidance or public reprimand? ☐ No ☐ Yes
- e. Have you voluntarily surrendered a medical license? ☐ No ☐ Yes
- f. Has any State/Medical Board placed you on probation or restricted your practice? ☐ No ☐ Yes
- g. Is your medical license currently under investigation for any reason in any state? ☐ No ☐ Yes
- h. Has your Narcotics/DEA license been surrendered/refused/suspended/revoked (voluntarily or otherwise)? ☐ No ☐ Yes
- i. Has there been any professional conduct or fee complaint filed against you with any Specialty, National, State or County Medical Society, other Professional Association or any licensing or regulatory authority? (e.g., AHCA/DPR/Board of Medicine or Health; Medicare/Medicaid; OSHA; EEOC; etc.) ☐ No ☐ Yes

IF YES to any of the above, describe circumstances, outcome, dates and attach copies of any relevant documents.

4. IN THE PAST 12 MONTHS:

- a. Have you become American Board Certified or Eligible? ☐ No ☐ Yes
- b. Has your board certification or membership in any medical association/society been refused, suspended, revoked or voluntarily surrendered? ☐ No ☐ Yes

5. **IN THE PAST 12 MONTHS:**

- a. Have you been evaluated, treated or recommended for treatment of alcohol, narcotics or any other substance abuse, sexual addiction or mental illness? ☐ No ☐ Yes
- b. Have you been diagnosed with, or treated for, a chronic physical illness and/or disability? ☐ No ☐ Yes
- c. Have you become aware of any physical illness, mental illness and/or disability which affects, or could affect, your ability to practice medicine now or anytime in the future? ☐ No ☐ Yes

IF YES to any of the above, describe circumstances, outcome, dates and attach copies of any relevant documents (including a letter from your treating physician addressing your state of health and whether such condition could adversely affect your ability to practice medicine).

6. **IN THE PAST 12 MONTHS**, have you been charged with or convicted of a felony or misdemeanor for **other than** a minor traffic violation? ☐ No ☐ Yes

IF YES, describe circumstances, outcome, dates and attach any relevant documents.

7. **IN THE PAST 12 MONTHS**, have your hospital privileges been suspended, denied, revoked, restricted or otherwise sanctioned? ☐ No ☐ Yes

IF YES, describe circumstances, outcome, dates and attach any relevant documents.

III. CURRENT MEDICAL PRACTICE

1. Do you employ, supervise or contract with **any other physicians**? ☐ No ☐ Yes

2. Do you employ, supervise or contract with any of the following? ☐ No ☐ Yes

NOTE: For the "Status" column, please indicate as follows:

'E' = Employee
'S' = Supervise only (i.e. not your employee)
'I/C' = Independent Contractor

No		Yes		Status: 'E', 'S' or 'I/C'	How many?	No		Yes		Status: 'E', 'S' or 'I/C'	How many?
☐	☐	Aesthetician		_____	_____	☐	☐	Optometrist and/or Optician		_____	_____
☐	☐	CRNA		_____	_____	☐	☐	Physical Therapist		_____	_____
☐	☐	Electrologist/Laser Tech		_____	_____	☐	☐	Physician Assistant		_____	_____
☐	☐	Lay Midwife		_____	_____	☐	☐	Registered Nurse		_____	_____
☐	☐	Nurse Anesthetist		_____	_____	☐	☐	Scrub Nurse (in OR)		_____	_____
☐	☐	Nurse Midwife		_____	_____	☐	☐	Surgeon Assistant		_____	_____
☐	☐	Nurse Practitioner		_____	_____	☐	☐	Med Tech/Other Assistants		_____	_____
☐	☐	Other: ↔ Description: _____									

3. Which of the following describes your practice?

☐ **No Surgery** — perform neither surgery nor obstetrical procedures. Incising of boils and superficial fascia, suturing or minor lacerations, removal of superficial skin lesions by other than surgical excision and assisting in surgery are not considered surgery.

☐ **Minor Surgery** — applies to all general practitioners or specialists, except those performing major surgery or anesthesiology, who may perform any of the following medical techniques or procedures: colonoscopy, endoscopic retrograde cholangiopancreatography (ERCP), pneumatic or mechanical esophageal dilation (not with bougie or olive), tonsillectomies, and adenoidectomies.

Please list types of procedures routinely performed: _____

☐ **Major Surgery** — includes operations in or upon any body cavity including, but not limited to, the cranium, thorax, abdomen, pelvis or any other operation which because of the condition of the patient or length of the circumstances of the operation presents a distance hazard to life. It also includes: removal of tumors, open bone fractures, amputations, termination of pregnancy, the removal of any gland or organ (excluding tonsillectomies and adenoidectomies), plastic surgery and any operation done using general anesthesia.

Please list types of procedures routinely performed and number per year: _____

4. Provide average number of patients seen per week: _____

5. Is any percentage of your practice devoted to practicing as a locum tenens? ☐ No ☐ Yes **IF YES**, what _____ %

6. **Are you professionally associated with** (either directly or indirectly) and/or do you provide professional services on behalf of and/or do you have a financial interest in any of following. Please answer all that apply.

No	Yes	Loc. Code #	Location Type	No	Yes	Loc. Code #	Location Type
☐	☐	01	Abortion Clinic	☐	☐	23	Industrial Firm Medical Care Facility
☐	☐	02	Administrative Position	☐	☐	24	Inpatient (bed/board) type Facility
☐	☐	03	Adult Congregate Living Facility	☐	☐	25	Massage Parlor/Establishment
☐	☐	04	Adult Day Care type Facility	☐	☐	26	Medical Laboratory
☐	☐	05	Ambulatory Surgery Center or Surgi-Center	☐	☐	27	Military Service (active or reserve)
☐	☐	06	Birth Center	☐	☐	28	Nursing Home
☐	☐	07	Chemotherapy or Infusion Center	☐	☐	29	Occupational or Orthopaedic Rehab Center
☐	☐	08	College/University Sports (team or individual)	☐	☐	30	Palliative Care
☐	☐	09	Cruise Ship	☐	☐	31	Paramedical Services
☐	☐	10	Day Spa	☐	☐	32	Pharmacy
☐	☐	11	Developmentally Disabled Facility	☐	☐	33	Private Practice
☐	☐	12	Dialysis Center	☐	☐	34	Psychiatric Facility
☐	☐	13	Educational Institution	☐	☐	35	Radiology and/or Imaging Center
☐	☐	14	Facial Salon	☐	☐	36	Rehabilitation Facility
☐	☐	15	Fitness Center	☐	☐	37	Sanatorium
☐	☐	16	Governmental Entity	☐	☐	38	Semi or Professional Sports (team or individual)
☐	☐	17	Grade or High School Sports (team or individual)	☐	☐	39	Tattoo Parlor/Establishment
☐	☐	18	Hair Restoration or Laser Hair Removal Clinic	☐	☐	40	Urgent Care or E-Care type facility
☐	☐	19	Home Health Care Services	☐	☐	41	Vein Clinic
☐	☐	20	Hospital-Based Practice	☐	☐	42	Walk-In Clinic
☐	☐	21	Hotel	☐	☐	43	Weight Loss Center
☐	☐	22	Other(s) ➔ please explain:				

Explain your professional and/or financial relationship with each: _____

7. **Do you perform the following procedures?**

A.	Elective cosmetic surgery	☐ No	☐ Yes	— % of practice:	%
B.	Itinerant surgery	☐ No	☐ Yes **		
C.	Vaginal deliveries	☐ No	☐ Yes	— # per year:	# of VBACs: _____
D.	Cesarean sections	☐ No	☐ Yes	— # per year:	
E.	Deliveries outside the hospital	☐ No	☐ Yes **		
F.	Abortions	☐ No	☐ Yes	— # per year:	% > 1st Trimester? ☐ No ☐ Yes
G.	Neonatology	☐ No	☐ Yes	— % of practice:	%
H.	Professional/collegiate sports medicine	☐ No	☐ Yes **		
I.	Angiography/arteriography/cardiac catheterization	☐ No	☐ Yes		
J.	Experimental procedures	☐ No	☐ Yes **		
K.	Weight control by drugs/diet only	☐ No	☐ Yes **	% of practice:	%
L.	Bariatric/Weight Control Surgery	☐ No	☐ Yes	— # per year:	
M.	Acupuncture	☐ No	☐ Yes	— % of practice:	%
N.	Botox Injections	☐ No	☐ Yes	— # per year:	
O.	Chemical Peels	☐ No	☐ Yes	— % of practice:	%
P.	Clinical Trials	☐ No	☐ Yes	— % of practice:	%
Q.	Collagen injections	☐ No	☐ Yes	— # per year:	
R.	Colonoscopy	☐ No	☐ Yes		
S.	Needle Biopsies	☐ No	☐ Yes		
T.	Organ Transplants	☐ No	☐ Yes		
U.	Penile Implants	☐ No	☐ Yes		
V.	Reconstructive Plastic Surgery	☐ No	☐ Yes		
W.	Sex change operations	☐ No	☐ Yes		
X.	Laser therapy	☐ No	☐ Yes **		

IF YES to any of the above marked with an asterisk (**), please explain fully under Section V. or on your letterhead.

8. Have you become a **Medical Director** or have you accepted similar type responsibilities for or on behalf of a medical office (not owned by you), hospital, nursing home, sanitarium, out-patient type facility or an entity providing patient / medical related services within the past year or anticipate doing so in the near future? ☐ No ☐ Yes
9. Have you provided professional services on behalf of a **jail, prison, correctional facility, detention center, halfway house** or similar type facility for adults and/or juveniles within the past year or anticipate doing so in the near future? ☐ No ☐ Yes
IF YES, provide total number of hours per month: _____
10. Have you performed/provided consultations, diagnosed and/or treated, provided medical advice and/or opinions, reviewed slides or specimens, prescribed medications, sold any products (as a distributor or for products you make, produce and/or manufacture), or sold any type of services via telecommunications, video, electronic information systems or the Internet? ☐ No ☐ Yes
IF YES, provide details (including list of states in which services were provided) under Section V. or on your letterhead.
11. Have you performed any procedures/surgeries considered to be experimental in nature **and/or** not currently approved by the FDA within the past year or anticipate doing so in the near future? ☐ No ☐ Yes
IF YES, provide details under Section V. or on your letterhead.
12. Have you become involved or associated with any devices (including implants) considered to be experimental? **and/or** not currently approved by the FDA? ☐ No ☐ Yes
IF YES, provide details under Section V. or on your letterhead:
13. Have you worked in a hospital Emergency Room **other than** to fulfill requirements for your hospital privileges? within the past year or anticipate doing so in the near future? ☐ No ☐ Yes

IV. CLAIMS HISTORY

1. **IN THE PAST 12 MONTHS**, have there been any claims made, incident surfacing and/or suit brought against you alleging damages resulting from a medical incident? ☐ No ☐ Yes
IF YES, have all such matters been reported to and acknowledged by CNA? ☐ No ☐ Yes
IF YES, have all such matters been reported to and acknowledged by any other insurance carrier? ☐ No ☐ Yes
COMPLETE A CLAIM SUPPLEMENTAL FORM OR A NARRATIVE ON YOUR LETTERHEAD PROVIDING COMPLETE DETAILS.
2. **IN THE PAST 12 MONTHS**, have any claim(s) reported on last year's application been adjudicated, settled, closed, dismissed or otherwise changed in status? ☐ No ☐ Yes
IF YES, please provide details: _____

V. COMMENTS SECTION

Question number	Comments

