McARTHUR INSURANCE AGENCY

Your Professional Liability Insurance Specialists

12605 Ulmerton Road Largo, Fl 33774 Phone: 800-982-0398 Fax: 800-749-6445 www.McArthurAgency.com

Application for Coverage

First Middle Last

Professional Designation:

MD DO APRN NP PA-C CRNA APN LPN OD OT PA PhD PT RN Other_____

Your Address

Street City County State Zip Code

Date of Birth: _____ NPI Number:_____

Medical Clinic you will be working for: _____

Are you replacing a current provider if so who? _____

Requested Effective Date: _____ Requested Retroactive Date: _____

Number of Hours of Worked Weekly_____ Number of Patients Seen Weekly_____

Medical Licensure

State: _____ State: _____ State: _____

License #: _____ License #: _____ License #: _____

Expiration Date: _____ Expiration Date: _____ Expiration Date: _____

DEA License Number: _____

Please provide a copy of licensure and/ or certification.

Education/Training please attach your CV

Procedures

1. Alternative Therapies	☐Yes	No ☐
2. Cosmetic - Anti-aging	☐Yes	No ☐
3. Hormone Therapy	☐Yes	No ☐
4. Stem Cell Therapy	☐Yes	No ☐
5. Stem Cell Harvesting	☐Yes	No ☐
6. Chelation Therapy or other Heavy Meta	☐Yes	No ☐
7. HCG	☐Yes	No ☐
8. Hyperbaric Oxygen Therapy	☐Yes	No ☐
9. Massage or Manipulation	☐Yes	No ☐
10. Ozone Therapy	☐Yes	No ☐
11. IV drip of any kind	☐Yes	No ☐
12. O and or P shot	☐Yes	No ☐
13. PRP	☐Yes	No ☐
14. Weight Loss	☐Yes	No ☐

Any Yes Answer please explain number of treatments on an annual basis

For MD's and DO's

1)Will you be the medical director for the practice? ☐ Yes ☐ No

2) Will you be the supervising or colaberating physician for the allied professionals in the office? ☐ Yes No ☐

3) Will you be doing any direct patient care? ☐ Yes No ☐

If yes please describe the patient treatment you will be doing? _____

For All Providers

1. Has your license to practice medicine or your permit to prescribe drugs, or your hospital staff privileges ever been denied, revoked, suspended, placed on probation, subjected to reprimand, voluntarily surrendered or in any other way limited, or has it been or is it currently under investigation? ☐ YES NO ☐

2. Has any insurance company ever canceled, declined to issue or refused to renew your professional liability insurance. ☐ YES NO ☐

3. Has any civil or criminal action ever been filed against you or have you been notified that any civil action will be filed against you alleging professional errors or omissions? ☐ YES NO ☐
Have any judgments been made against you, or any out-of-court settlements been made on your behalf, from an incident alleging medical errors or omissions? ☐ YES NO ☐

4. Have you ever been treated or evaluated for alcoholism or drug addiction, psyschiatric / psychological treatment or evaluation, Have you received any major medical / surgical treatment or evaluation for illness or accident ☐ YES NO ☐

STATEMENT OF NO KNOWN CLAIMS or CIRCUMSTANCES

I, _____, represent that on behalf of all physicians, physician extenders, and employees of my practice, have no knowledge of any incidents, or lawsuits, or any potential incidents, claims, or suits arising from an alleged act or omission resulting from the rendering or failure to render professional services by me or by any person for whose acts or omissions I am legally responsible.

Please answer the following questions and if you do have knowledge of any of the above actions, attach a description of each.

1. Has there been a formal claim that you have not yet reported? _____
2. Have there been any requests for medical records that may lead to a claim? _____
3. Do you know of any incidents that may lead to a claim? (An incident could be defined as any fact, circumstance, or situation indicating the possibility of a claim) _____

Applicant: _____ Title: _____

Applicants Signature: _____ Date: _____

Agent/Broker Name: _____