Professional Liability Application for Medical Directors

ISC

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 Outpatient 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 within his/her capacity as a "physician" 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 will provide services as Medical Director: _____
12. Remuneration – annual remuneration applicant will be paid for services 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: _____

Send submissions to: healthcare@iscmga.com

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 five (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, and 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 or Relationship:

I. 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 manner, except as Medical Director, affiliated or associated with said organization.

II. 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 Underwriters 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 the 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 Signature/Title

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