Correctional Medical

Named Physician Coverage Supplemental Application

Note: a current Curriculum Vitae must accompany each completed and signed application.

1. Name of Applicant: _____

2. Organization Name: _____

3. Are you requesting Prior Acts Coverage? ☐ Yes ☐ No If yes, specify Retroactive Date:_____

4. Does your employment with the above organization require that you provide services to any other organization?
   ☐ Yes ☐ No (If yes, provide details in Comments Section.)

5. Medical School/State: _____ Degree: ☐ M.D. ☐ O.D. ☐ Other: _____
   Month/Year Graduated: _____
   Are you currently a resident, intern, or fellow? ☐ Yes ☐ No If yes, dates you will complete training: _____

6. List all states where you are licensed to practice and license numbers:
   State/License Number: _____/_____ State/License Number: _____/_____
   State/License Number: _____/_____ State/License Number: _____/_____

7. Indicate percentage of thee devoted to the following medical and/or surgical activities (total = 100%):

_____ Allergy & Immunology
_____ Anesthesiology
_____ Broncho-Esophagology
_____ Cardiovascular Disease
_____ Colon & Rectal
_____ Dermatology
_____ Diabetes
_____ Emergency Medicine
_____ Endocrinology
_____ Family Practice or General Practice, Excl OB
_____ Family Practice or General Practice, Incl OB
_____ Fetal & Maternal Medicine
_____ Foot & Ankle Surgery
_____ Gastroenterology
_____ General Preventative Medicine
_____ Geriatrics
_____ Gynecology
_____ Hand
_____ Head & Neck
_____ Hematology
_____ Infectious Diseases
_____ Intensive Care Medicine
_____ Internal Medicine
_____ Larynology
_____ Limited General Practice
_____ Legal Medicine
_____ Neoplastic Diseases
_____ Nephrology
_____ Neurology
_____ Nuclear Medicine
_____ Nutrition
_____ Obstetrics/Pre-Natal Care
_____ Oncology
_____ Opthamology
_____ Oral-Maxillofacial Surgery
_____ Orthopedics
_____ Otology
_____ Otorhinolaryngology
_____ Pain Management
_____ Pathology
_____ Pharmacology
_____ Physiatry
_____ Physician-NOC
_____ Physical Medicine and Rehabilitation
_____ Psychiatry
_____ Psychoanalysis
_____ Psychosomatic Medicine
_____ Public Health
_____ Pulmonary Diseases
_____ Radiology
_____ Rheumatology
_____ Rhinology
_____ Teleradiology
_____ Thoracic
_____ Urology
_____ Weight Reduction/Control
_____ Other (list): _____

SURGERY
_____ Abdominal
_____ Bariatric
_____ Cardiac
_____ Cardiovascular
_____ Colon & Rectal
_____ Dermatology
_____ Endocrinology
_____ Foot & Ankle
_____ Gastroenterology
_____ General
_____ Gynecology
_____ Hand
_____ Head & Neck
_____ Laryngology
_____ Neonatal
_____ Neoplastic
_____ Nephrology
_____ Neurology
_____ Obstetrics
_____ Ophthalmology
_____ Orthopaedic Excl Spine
_____ Orthopaedic Incl Spine
_____ Otorhinolaryngology
_____ Perinatology
_____ Plastic
_____ Plastic-Otorhinolaryngology
_____ Thoracic
_____ Traumatic
_____ Urological
_____ Vascular
_____ Other (list): _____

8. Medical Specialty:
   Are you certified by an approved specialty board? ☐ Yes ☐ No
   If yes – American Board of _____ Cert # _____
   Date Issued: _____ Expiration Date: _____

Primary Medical Specialty: _____ Sub Specialty: _____

If your practice limited to your sub-specialty? ☐ Yes ☐ No

If you are NOT board eligible or certified, please explain in the Comments section below.

9. Profile Questions: **Please provide details to any "Yes" responses in the Comments section below.**

a. Has any organization ever denied, restricted, suspended, or revoked your privileges or practice; have you ever voluntarily surrendered your privileges; or has probation or a consent order ever been invoked? ☐ Yes ☐ No

b. Has any organization notified you of its intention of consider imposing any change of status, penalties, privileges, participation, certification, or membership? ☐ Yes ☐ No

c. Has your narcotics or medical license ever been suspended, restricted, revoked, or voluntarily surrendered or has probation been invoked? ☐ Yes ☐ No

d. Have you been asked to participate in or have you volunteered to participate in an impaired physician program? (If Yes, please attach a copy of your recovery plan document.) ☐ Yes ☐ No

e. Have you ever been denied a medical license or been denied certification by a specialty board? ☐ Yes ☐ No

f. Do you have knowledge of any claims, potential claims, or suits in which you may become involved, including without limitation knowledge of any alleged injury arising out of the rendering or failure to render professional services which may give rise to a claim? ☐ Yes ☐ No
If yes, have these been reported to your present carrier?
Complete and attach a Claim Information Form for EACH such claim, potential claim, or suit or provide a recent carrier claim history.

g. Has any medical professional liability insurance ever been declined, canceled, non-renewed, surcharged or conditioned? ☐ Yes ☐ No
NOTE: **MISSOURI APPLICANTS DO NOT RESPOND**

Comments Section:

_____

_____

_____

_____

_____
Applicant Signature

_____
Print Name

_____
Date:

CLAIM INFORMATION FORM

Complete and attach a Claim Information Form for EACH claim, potential claim, or suit.

Claimant First Name: _____ Middle Name: _____ Last Name: _____

Age: _____ Gender: ☐ Male ☐ Female

Date(s) of treatment and/or surgery, which lead to the allegations against you: _____

Nature of the allegations in the claim or suit: _____

Was suit ever filed: ☐ Yes ☐ No If yes, when was it filed? _____

Name of other doctor(s) and hospital(s), if any, involved in claim or suit: _____

Disposition or current status of claim or suite: ☐ Open ☐ Closed

If open, indicate case value established by carrier: $ _____

If closed, was payment made? ☐ Yes ☐ No If no, was claim or suit withdrawn? ☐ Yes ☐ No

If payment was made, indicate total amount of settlement or award: _____

How much was on your behalf: _____

Name of insurance carrier defending you: _____

Narrative description of the medical facts (must include the type of treatment and/or surgery and your involvement). Please give as complete a narrative description as possible.

_____

_____

_____

Claimant First Name: _____ Middle Name: _____ Last Name: _____

Age: _____ Gender: ☐ Male ☐ Female

Date(s) of treatment and/or surgery, which lead to the allegations against you: _____

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_____

_____

_____