

## PHYSICIAN'S MEDICAL SPA PROFESSIONAL LIABILITY APPLICATION (CLAIMS MADE COVERAGE)

### PHYSICIAN'S PERSONAL INFORMATION

1) Full Name of Applicant:

2) Mailing Address:

3) Medical License # and State of Issuance:

4) Social Security #:

5) DEA#

6) Date of Birth:

7) Place of Birth:

8) Medical School & Year of Graduation:

9) Medical Specialty:  Sub Specialty:

\*Unless your specialty is Dermatology, Aesthetics, Anti-Aging or Plastic/Cosmetic Surgery, please attach Certificates of Training for the procedures you will be performing outside your specialty.

10) Are you American Board Certified?  YES  NO

If Yes, in what specialty?

Year Certified:

### MEDISPA INFORMATION

11) Name & Location of Medical Spa (s) where services will be performed:

12) Your relationship to this entity:

Owner/Partner

Independent Contractor

Employee

Other - Please Describe

13) When did you begin providing medical services at this facility?

14) Please indicate the estimated number of procedures that will be preformed over the next 12 months:

<b>PROCEDURE</b>	<b># Per Year</b>	<b>PROCEDURE</b>	<b># Per Year</b>	<b>PROCEDURE</b>	<b># Per Year</b>
Abdominoplasty	<input type="text"/>	Injectable/Dermal Fillers *	<input type="text"/>	Pigmented Lesion Removal	<input type="text"/>
Acne Treatment	<input type="text"/>	IPL & Photofacial Rejuvenation	<input type="text"/>	Sclerotherapy	<input type="text"/>
Acupuncture	<input type="text"/>	Lipolysis - Laser (Smart Lipo)	<input type="text"/>	Skin Tag Removal	<input type="text"/>
BHRT (Bioidentical Hormone Replacement Therapy)	<input type="text"/>	Liposuction	<input type="text"/>	Tattoo Removal	<input type="text"/>
Breast Augmentation	<input type="text"/>	Laser Cellulite Treatment	<input type="text"/>	Teeth Whitening	<input type="text"/>
Brown Spot Removal	<input type="text"/>	Laser Hair Removal	<input type="text"/>	Thermage	<input type="text"/>
Chemical Peels (Light)	<input type="text"/>	Laser Skin Resurfacing	<input type="text"/>	Vein Treatment	<input type="text"/>
Chemical Peels (Medium to Heavy)	<input type="text"/>	Lipodissolve	<input type="text"/>	Wart Removal	<input type="text"/>
Contour Thread Lifts	<input type="text"/>	Liposelection	<input type="text"/>	Waxing	<input type="text"/>
Dermaplaning	<input type="text"/>	Lipolysis - Injection	<input type="text"/>	Weight Loss Mgmt	<input type="text"/>
Ear Candling	<input type="text"/>	Massage	<input type="text"/>	Other	<input type="text"/>
Electrolysis	<input type="text"/>	Mesoderm	<input type="text"/>	Other	<input type="text"/>
Hair Transplants	<input type="text"/>	Mesotherapy	<input type="text"/>	Other	<input type="text"/>
HCG	<input type="text"/>	Microdermabrasion	<input type="text"/>	<b>Total of Procedures</b>	
Hyperbaric Treatment	<input type="text"/>	Permanent Makeup	<input type="text"/>		

\* Injectable/Dermal Fillers: Include Artefill, Botox, Captique, Collagen, Hylaform, Juvederm, Radiesse, Restylane, Sculptra

\* IF YOU PERFORM A PROCEDURE THAT IS CALLED BY A DIFFERENT NAME, BUT ESSENTIALLY THE SAME AS ANY OF THE ABOVE PROCEDURES, PLEASE ANSWER THE QUESTION ACCORDINGLY.

\*IF YOU PERFORM SURGICAL PROCEDURES OTHER THAN THOSE SHOWN ABOVE, PLEASE ATTACH A LIST OF THOSE PROCEDURES AND THE NUMBER OF ANTICIPATED PATIENT ENCOUNTERS FOR THE NEXT 12 MONTHS.

**PRIOR INSURANCE AND CLAIM INFORMATION**

15) Do you currently carry Professional Liability Insurance for your medical services provided outside of this facility? If Yes, please provide details for the past 5 years:  YES  NO

<u>Company</u>	<u>Policy Term</u>	<u>Limits of Liability</u>	<u>Retro Date</u>	<u>Premium</u>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

16) Has any claim ever been made against you for Medical Malpractice? [Form Link](#)  YES  NO

17) Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer? [Form Link](#)  YES  NO

18) Are you aware of any circumstances which may result in a claim against you for medical malpractice?  YES  NO

19) Have you ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association? If Yes, please provide a written explanation below and attach a copy of the Complaint, Consent Order document if applicable.  YES  NO

20) Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?  YES  NO  
If Yes, please provide a written explanation below.

21) Have you ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required you to be evaluated for an alleged mental condition and/or alcohol or drug addiction?  YES  NO  
If Yes, please provide a written explanation below.

22) Have you ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?  YES  NO  
If Yes, please provide a written explanation below.

23) Have you ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms?  YES  NO  
If Yes, please provide a written explanation below.

### **MEDICAL DIRECTOR INFORMATION**

24) Do you also provide Medical Director Services for this Medical Spa?  YES  NO  
If Yes, please complete Questions # 25-30 below.

25) How many hours per week are dedicated to medical director services only?

26) How long have you worked as medical director at this facility?

27) Please describe your duties as medical director:

28) List the number and type of employees that you supervise at this facility:

Type of Professional	#	Type of Professional	#	Type of Professional	#
Physician(s)	<input type="text"/>	Registered Nurse(s)	<input type="text"/>	Laser Technicians	<input type="text"/>
Physician's Assistant(s)	<input type="text"/>	LPN's	<input type="text"/>	Other	<input type="text"/>
Nurse Practitioner (s)	<input type="text"/>	Medical Aesthetician(s)	<input type="text"/>	Other	<input type="text"/>

29) Has any claim ever been made against you solely as respects your duties as a medical director. If Yes, complete the Supplemental Claim Information Form for each claim. Also, please attach five years of currently valued company loss runs.  YES  NO

30) Are you aware of any circumstances, solely as respect your duties as a medical director, which may result in a claim against you? If Yes, please provide a written explanation below.  YES  NO

I/We declare that I/we have reviewed this Application for accuracy before signing it, that the above statements and representations are true and correct, and that no facts have been suppressed or misstated. I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We nevertheless acknowledge that any contract of insurance issued by the Company in response to this Application will be in full reliance upon the statements and representations made in this Application and that this Application will be made part of the policy. I/We understand that any contract of insurance issued by the Company in response to this Application will be issued on a claims made form.

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance, or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:

Current Date

Title

**If you prefer not to Return Application with an Electronic Signature, Please print and Sign Below:**

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this electronically submitted application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this electronic application and this application will be made part of the policy. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

Type or print your name & title

Type or print your phone number

Type or print your e-mail address

Date

**Please attach copies of the following documents:**

- \* A minimum of five years of currently valued company loss runs.
- \* CV or Resume
- \* Unless your specialty is Dermatology, Aesthetics, Anti-Aging or Plastic/Cosmetic Surgery, please attach Certificates of Training for the procedures you will be performing outside your specialty.

**Additional Comments or Details:**