Dermatology, Cosmetic Surgery, Plastic Surgery, Aesthetic Surgery Application Supplement

Note: This application must be completed by all physicians performing any procedures similar to the above.

1. Are you board certified Yes No
   a. What is your area of certification?

   ____

2. What best describes your practice:

   My practice is general office dermatology including the incision of boils and superficial abscesses of suturing and superficial fascia, removal of skin lesions such as skin cancers, keratosis, etc., all involving local anesthesia.

   I perform cosmetic or plastic surgery procedures.

   I perform liposuction.

   Lasers are used in my practice.

3. What percentage of your practice is elective cosmetic surgery? ______
4. What percentage of your practice is reconstructive surgery including congenital defects? ______
5. Do you assist in surgery? Yes No
6. Do you have staff members performing laser procedures? Yes No

   If yes, please explain which procedures are performed, which staff members are performing them and their credentials and training for doing so:

Do you utilize any non-physician healthcare providers, such as but not limited to medical assistants, nurses, aestheticians, etc., for the performance of any cosmetic procedure noted on this application?

Yes No

Do you want coverage for these providers? Yes No

If "yes", please include a non-physicians application and procedure list separately.

Are these providers employed by you or independent contractors ?

Are they physically located at your office and under your supervision at all times or are they operating independently at a location where you are not physically present at all times?

Where do you perform the procedures you have noted?

Non-surgical office setting
Surgical suite within office
Outpatient surgical facility Name of facility:
Hospital Name of facility:
Other

For any of the above, are patients kept overnight? Yes No

For any of the facilities noted above, please indicate any facility accreditation and licensure that apply.

In your office practice, do you use Conscious Sedation General Anesthesia neither
If so, who administers and who monitors and recovers the patient?

If so, is training|CME obtained annually or biannually in anesthesia administration?

If you perform procedures in your own office or free standing facility:

Are you on staff at a hospital where the patient can be admitted for an overnight stay or in case of an emergency? Yes No
Do you have emergency and transfer protocols in writing? Yes No
Are you and your staff ACLS certified? Yes No
What resuscitative equipment do you have and maintain in your office?

Do you advertise your name, phone number and performance of these cosmetic procedures noted in any manner other than a one-line listing in the white or yellow pages? Yes No
If “yes” attach a sample of your display ad(s) and all other media advertisements. If you use radio and/or TV, please attach a separate information sheet regarding these activities and include a copy of the script.
If you have a website, please supply us with the web address and a copy of the home page.

For each cosmetic procedure you perform, please provide the following information:

- Evidence of training in the procedure, including any certificates of courses completed
- Patient selection protocol
- Informed consent document.

Procedures List

Please check ALL procedures you are performing

- ❑Abdominoplasty
- ❑Blepharoplasty
- ❑Botox/Dermal Fillers
- ❑Bracheoplasty
- ❑Breast Augmentation
  with Silicone ❑ Yes ❑ No
- ❑Breast (Open) Capsulectomy
- ❑Breast Reduction
- ❑Browplasty- Direct
- ❑Fat Extraction
- ❑Buttock implant
- ❑Calf Implant
- ❑Chin Implant
- ❑Collagen Injection
- ❑Cosmetic Tattooing
- ❑Deep Vein sclerotherapy
- ❑Facelift (of any kind)
- ❑Fat Transplantation
- ❑Genioplasty
- ❑Hair Flaps
- ❑HairTransplant
- ❑Injection Sclerotherapy of Cutaneous Ectasia
- ❑Jaw Implant
- ❑Laser Destruction of Tattoos
- ❑Laser Hair Removal
- ❑Laser Skin Resurfacing
- ❑Laser Skin Tightening
- ❑Laser Surgery of Vascular Lesions
- ❑Liposuction – General or Deep Sedation
  - ❑Tumescent liposuction
  - ❑Lipo Lite
  - ❑Lipo Dissolve (Mesotherapy)
- ❑Mandibular Osteotomy
- ❑Mastopexy
- ❑Maxillary-zygoma Augmentation
- ❑Nasal Implant|Augmentation
- ❑Neckplasty (not as part of facelift)
- ❑O-Shot
- ❑Osteomy (ies) of Maxilla
- ❑Otoplasty
- ❑Peels and Facial Procedures
  - ❑Chemical Peels
  - ❑Dermabrasions
  - ❑Phenol Peels
  - ❑Photofacial
  - ❑Scar Dermabrasions

- ❑Superficial Chemical Peels (glycolic, Jessner, TCA 30% concentration or less, etc,)
- ❑TCA 50% Peels
- ❑TCA Peels (Augmented with C02, AHA, methylsalicylate, factors 272, or Jessner's solution)
- ❑Priapus Shot
- ❑Prolotherapy
- ❑Rhinoplasty including augmentation
- ❑Scalp Reduction
- ❑Scar Dermabrasion
- ❑Scar Laser Resurfacing
- ❑Scar Revision
- ❑Silhouette Face Lift
- ❑Skin Flap Reconstruction
- ❑Skins (scrape) biopsy
- ❑Skin Grafts
- ❑Soft Tissue Augmentation (Gore-Tex etc.)
- ❑Steroid injection for cosmetic reasons
- ❑Teeth Whitening
- ❑Ultra violet light (List procedures below)
- ❑Vaginoplasty
- ❑Vampire Shot

Other (please list any and all other dermatology, cosmetic, aesthetic or plastic surgery procedures you perform that are not listed above. Provide a separate sheet if necessary).

Specify any procedures not listed above NOT generally considered part of your speicialty for which you would like to be insured.

INFORMATION IN THIS DOCUMENT WILL BECOME PART OF YOUR POLICY.

____ ________________

Physicians Signature *Date*