



PROFESSIONAL LIABILITY ASSOCIATION, LLC

CARE RISK RETENTION GROUP, INC

GENERAL SURGERY SUPPLEMENT

1. Do you perform any orthopedic procedures? [] Yes [] No

If yes, describe thoroughly: _____

2. Approximately what percentage of your practice do the following comprise?

Abdominal surgery _____% Bariatric surgery _____% Chest surgery _____%

Gynecological surgery _____% Vascular surgery _____%

3. Do you perform itinerant surgery? [] Yes [] No

If yes, explain:

a. Responsibility of post-operative supervision and care of patient: _____

b. List procedures you perform in your "out of town" practice: _____

4. Do you perform organ transplants? [] Yes [] No

If yes, which organs? _____

5. Do you perform surgery on upper extremities?

Hands? [] Yes [] No

What percentage of your practice? _____%

Shoulders? [] Yes [] No

What percentage of your practice? _____%

Other? [] Yes [] No

What percentage of your practice? _____%

6. Do you take ER calls? [] Yes [] No

7. Do you perform any cosmetic surgery? Yes No

If yes, please complete the plastic surgery supplement.

8. Do you perform implantation or injection of silicone or other materials for cosmetic purposes?

Yes No

9. Do you perform any thoracic surgery other than emergency chest tube placement and follow-up?

Yes No

If yes, describe: _____

10. Do you practice any of the following Ob/Gyn procedures?

a. Diagnostic laparoscopy

b. Tubal sterilization

c. Pelvic surgery incl. Hysterectomy

d. Extensive pelvic cancer surgery

e. Caesarean sections

f. Therapeutic or elective abortions First Trimester Second Trimester

Do you practice any other Obstetrics? Yes No

If yes, please list: _____

11. Do you do any catheterization-arterial, cardiac or diagnostic – OTHER THAN

- Occasional emergency insertion of central venous recording catheters of temporary pacemakers,
- Urethral catheterization,
- Umbilical cord catheterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen?

Yes No

12. Do you do any weight control surgery? Yes No

If yes, please describe: _____

What percent of your practice does this comprise? _____

13. Are there any procedures not listed above or not generally considered part of your specialty for which You would like to have coverage? If so, please list and explain: _____

Physician's Signature

Date

It is important that you keep us informed of any changes in your practice so that we can provide you with adequate coverage.