PROFESSIONAL LIABILITY ASSOCIATION, LLC

CARE RISK RETENTION GROUP, INC

MEDICAL DIRECTORSHIP SUPPLEMENTAL APPLICATION

1. Name and location where Medical Director Services are Performed:
_____
_____
_____

2. Your relationship to this entity: ___Owner/partner ___ Contractor ___ Employee ____Other
(Provide Details:)
_____
_____

3. Type of Facility: (Describe medical services provided)
_____
_____

4. Please indicate below the Medical services or responsibilities that you will be required to perform in your capacity as Medical Director and for which you are seeking liability insurance coverage

____ Y _____N ADMINISTRATIVE DUTIES-being defined as established general medical protocol, serving on a standards review, peer review or credentialing committee or similar professional board or committee.
If yes, do you want coverage for this exposure? _____Y _____ N.

____ Y _____N DIRECT PATIENT CARE –being defined as rendering or failure to render your professional medical services in the examination, diagnosis, testing and/or the medical treatment of patients.
If yes, do you want coverage for this exposure? _____Y _____ N.
(If you currently carry your own individual medical liability insurance policy and you are certain your existing policy covers this Direct Patient Care exposure, please provide a copy of your current insurance.)

____ Y ____ N SUPERVISION- will your duties and responsibility as Medical Director require you render "patient specific" medical directives, medical direction, course of medical treatment or any other "patient specific" guidance to other healthcare professionals whom you oversee, manage or have collaborative agreements and collaborative responsibility? This includes signing charts and any and all means of telecommunications or other forms of communication between yourself and another healthcare professional related to "patient specific" guidance.
If yes, do you want coverage for this exposure? _____Y _____ N.
(If you currently carry your own individual medical liability insurance policy and you are certain your existing policy covers this Direct Patient Care exposure, please provide a copy of your current insurance.)

5. Surgery Performed at the facility?_____ Y _____ N

6. Facility currently carrying Malpractice coverage? _____Y ____ N

If yes, who is the carrier: _____
(***Attach copy of Declarations page)***

7. Employees supervised? *If "yes", indicate number below and attach non-physician application for each*
Lab Techs _____ Nurse Practitioner ____ Nurse Anesthetists _____ RNs _____

Nurse LPNs _____ Other _____

8. Does the facility have a Commercial General Liability Policy _____ Y _____ N

If yes, with whom? _____

9. How many hours a week are dedicated to medical director services only? _____

10. How long have you been medical director at this facility? _____

11. Do you provide any patient care at this facility? _____Y _____N

12. Are you available for consults for hours other than when you are there?_____

If "Yes", approximately how many hours per week? _____

13. Are all professional employees covered on the facility policy or on their own policy? ___Y ___N

14. Are Cosmetic procedures performed by non-physicians? _____ Y _____ N
If "yes" describe procedures performed and by whom:

_____

_____

THIS POLICY DOES NOT COVER ANY EMPLOYEES AT THE FACILITY

Print Name_____ Date _____

Signature _____

All questions must be answered and all required documents attached before coverage cannot be bound.