Risk Placement Services, Inc.
PO Box 834
Poulsbo WA 98370

Licensed Practitioner of the Healing Arts SUPPLEMENTAL APPLICATION

INSTRUCTIONS: **A Licensed Practitioner of the healing arts application must be completed for each practitioner to be named on the policy.** Please complete the entire form and attach curriculum vitae. If a section does not apply or is not relevant, answer "N/A" or "none". Information provided by you will be used by underwriters in determining the acceptability of adding the specific practitioner to the professional insurance coverage.

1. Your Name _____
2. Agency/Organization Name_____
3. Medical Specialty _____ Are you Board Certified? Yes___ No___
4. License Number/State _____
5. Is the coverage requested to be on a Primary or Excess basis? _____
   (If Excess is requested, minimum underlying limits of $1,000,000 per claim must be verified and a copy of the Physicians primary declaration page must be attached)
6. What is your working relationship with the Clinic/Center/Organization? Employee___ Contractor___ Volunteer___
7. Hours per week you work on behalf of the Organization? _____How many weeks per year? _____
8. List the responsibilities/duties you perform for the Organization (please be specific).

_____

_____

_____

9. Do you or will you perform any of the following medical procedures or services on behalf of the Organization?
   Yes___ No___ If yes, how many per year?____

	Times/yr.	None		Times/yr.	None
Entry Level Physicals	_____	_____	Medical Detox.	_____	_____
Methadone Treatment	_____	_____	HIV/AIDS Treatment	_____	_____
Infant/Child Medical Care	_____	_____	Prescribing Medications	_____	_____

10. Do you provide any other medical procedures or service on behalf of the Organization?Yes___ No___
    If yes, please describe below:
    _____
    _____
11. Do you obtain consent to treat patients? Yes___ No___
12. If the patient requires more specialized care, do you refer the patient to a specialist? Yes___ No___
    If yes, how do you determine the specialist that you refer the patient to?

_____

_____

_____

13. Do you admit patients to the hospital? Yes___ No___ Discharge patients from the hospital? Yes___ No___
14. Have you ever had a malpractice claim or suit filed against you? Yes___ No___
    (If yes, please attach detailed claim information and a detailed description for each claim or allegation.)
15. Have all known potential claims, incidents or suits, if any, been reported to your present carrier? Yes___No___
16. Have you ever had your medical license revoked, suspended, restricted or placed on probation? Yes___No___
17. Has your license to practice medicine or medical staff privileges or appointment to a hospital ever been suspended, voluntarily withdrawn, reduced, withheld, denied, revoked or subjected to any disciplinary action? Yes___No___
    (If yes, describe circumstances.)_____
    _____
18. Have you ever been the subject of an investigation, disciplinary proceeding or reprimand? Yes___ No___
19. Have you ever been convicted of a crime or felony? Yes___ No___
20. Have you ever been treated for alcoholism or drug addiction? Yes___ No___
21. Provide information on **<u>your</u>** in-force malpractice insurance. (if none exists, please indicate "none")
    a. Insurance Company Name _____Expiration date _____
    b. Limits of Liability $_____Policy # _____
    c. Does your malpractice policy cover you while performing work for the agency/organization? Yes___
       No___

NOTICE TO APPLICANT – PLEASE READ CAREFULLY

FOR THE PURPOSE OF THIS APPLICATION, THE UNDERSIGNED, AS AUTHORIZED AGENT FOR ALL PERSONS AND ENTITIES PROPOSED FOR THIS INSURANCE, DECLARES THAT TO THE BEST OF HIS/HER KNOWLEDGE THE STATEMENTS HEREIN ARE TRUE AND COMPLETE. THE INSURER IS AUTHORIZED TO MAKE ANY INQUIRY IN CONNECTION WITH THIS APPLICATION. SIGNING THIS APPLICATION DOES NOT BIND THE INSURER TO ISSUE, OR THE APPLICANT TO PURCHASE, ANY INSURANCE POLICY.

THE INFORMATION CONTAINED IN AND SUBMITTED WITH THIS APPLICATION IS ON FILE WITH THE INSURER. IF THE INFORMATION IN THIS APPLICATION MATERIALLY CHANGES PRIOR TO THE EFFECTIVE DATE OF THE POLICY, THE APPLICANT MUST NOTIFY THE INSURER, WHO MAY MODIFY OR WITHDRAW THE QUOTATION.

(WORDS WITHIN QUOTATION MARKS ARE DEFINED IN THE INSURANCE POLICY.)

_____ _____/_____/_____
Licensed Practitioner's Signature Date

_____ _____/_____/_____
Signature of Applicant Date

_____
Name and Title