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If you obtained this application at [www.markelshand.com](http://www.markelshand.com), please submit this application through your local insurance professional.

## APPLICATION FOR NURSE ANESTHETISTS PROFESSIONAL LIABILITY INSURANCE

NOTICE: The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

### I. GENERAL INFORMATION

1. (a) (i) Full name of Applicant: \_\_\_\_\_  
 (ii) Professional Degree: \_\_\_\_\_
- (b) Principal business address: \_\_\_\_\_  
 \_\_\_\_\_ (Street) \_\_\_\_\_ (County)  
 \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip)
- (c) (i) Phone: \_\_\_\_\_ (ii) Fax: \_\_\_\_\_  
 (iii) E-Mail Address: \_\_\_\_\_ (iv) Website Address: \_\_\_\_\_
- (d) (i) Date of Birth (MM/DD/YYYY): \_\_\_\_\_ (ii) Place of Birth: \_\_\_\_\_
2. (a) Requested Effective Date: \_\_\_\_\_ (b) Requested Retroactive Date: \_\_\_\_\_
3. Are you a U.S. citizen? ..... [ ] Yes [ ] No  
 If No, what is your status in the U.S. and current citizenship? \_\_\_\_\_
4. (a) Type of practice for which coverage is requested:  
 solo practitioner (unincorporated)                       solo practitioner (incorporated)\*  
 employee of \_\_\_\_\_                                       employee of locum tenens company  
 independent contractor of \_\_\_\_\_                       free-lance locum tenens  
 independent contractor of locum tenens company  
 \* Specify name of entity: \_\_\_\_\_
- (b) The practice for which coverage is requested is:  
 full-time     part-time     "moonlighting"  
 If the practice for which coverage is requested is part-time or "moonlighting" answer the following:  
 (i) Provide the name and address of your full-time position and number of weekly hours not including on-call.  
 \_\_\_\_\_  
 (ii) Attach a Certificate of Insurance evidencing that you have Professional Liability Insurance for your full-time practice.
5. Do you own a locum tenens company? ..... [ ] Yes [ ] No  
 If Yes, are you requesting coverage for this company? ..... [ ] Yes [ ] No  
 (i) If No, attach a Certificate of Insurance for Professional Liability Insurance for locum tenens company.  
 (ii) If Yes, complete our Locum Tenens and Contract Staffing Application (SM6210).

6. Do you work for and/or accept work assignments or placements from any locum tenens company? .....  Yes  No  
 If Yes, complete the following for each company:

<u>Name of Company</u>	<u>Address</u>	<u>Employee or Independent Contractor</u>	<u>No. of Hrs. Each Month</u>	<u>Is Prof. Liab. Insurance Provided to You? (Yes/No)*</u>
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\* If Yes, attach a copy of your Certificate of Insurance.  
 If No, are you requesting coverage for this activity? .....  Yes  No

7. Are you a free-lance locum tenens not placed by or associated with any locum tenens company? .....  Yes  No  
 8. Are you currently in active military service? .....  Yes  No  
 9. Provide the following information for all of the states in which you practice:

<u>State</u>	<u>License No.</u>	<u>Effective Date</u>	<u>Expiration Date</u>	<u>Active (Yes/No)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

10. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? .....  Yes  No  
 If Yes,  
 (i) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? .....  Yes  No  
 (ii) Provide the name and title of the Applicant's Privacy Officer. \_\_\_\_\_  
 Our Business Associate Agreement is available at [www.markelcorp.com](http://www.markelcorp.com). This is the only Business Associate Agreement we will recognize.

## II. EDUCATION AND TRAINING

1. Provide the following information:
- |                 | <u>Name of Institution</u> | <u>City</u> | <u>State</u> | <u>Date Completed</u> |
|-----------------|----------------------------|-------------|--------------|-----------------------|
| Nursing School  | _____                      | _____       | _____        | _____                 |
| Graduate School | _____                      | _____       | _____        | _____                 |
2. Provide a detailed summary of where you have practiced your profession since completing your training: \_\_\_\_\_  
 \_\_\_\_\_
3. Are you a member of any professional societies? .....  Yes  No  
 If Yes, provide information regarding your membership(s). \_\_\_\_\_

## III. SCOPE OF PRACTICE

1. (a) Principal practice location for which coverage is requested:
- |                 |               |
|-----------------|---------------|
| _____           | _____         |
| (Practice Name) | (Street)      |
| _____           | _____         |
| (City)          | (State) (Zip) |
- (b) Provide the number of weekly hours for your principal practice location (exclude on-call hours). \_\_\_\_\_  
 (c) Your principal practice location is a(n):  
 Hospital  Ambulatory Surgery Center  Professional Office with Specialty
2. (a) Secondary practice location for which coverage is requested. (If none, check here  )
- |                 |               |
|-----------------|---------------|
| _____           | _____         |
| (Practice Name) | (Street)      |
| _____           | _____         |
| (City)          | (State) (Zip) |
- (b) Provide the number of weekly hours for your secondary practice location (exclude on-call hours). \_\_\_\_\_

(c) Your secondary practice location is a(n):

Hospital     Ambulatory Surgery Center     Professional Office with Specialty

3. Are you supervised by an Anesthesiologist at each location for which coverage is requested? .....[  Yes [  No  
If Yes, is 100% of your practice supervised by an Anesthesiologist? .....[  Yes [  No  
If No, what percentage of your practice is supervised by the following:

\_\_\_% Another CRNA            \_\_\_% Dentist/Oral Surgeon            \_\_\_% Podiatrist  
\_\_\_% Anesthesiologist        \_\_\_% Ophthalmologist                \_\_\_% Other Physician \_\_\_\_\_  
\_\_\_% Bariatric Surgeon        \_\_\_% Plastic/Cosmetic Surgeon

4. Indicate the approximate percentages of your patients for which coverage is requested:

\_\_\_% Bariatric Surgery    \_\_\_% Dental/Oral Surgery    \_\_\_% Obstetrical    \_\_\_% Ophthalmological  
\_\_\_% Pediatric            \_\_\_% Podiatric                \_\_\_% Plastic or Other Cosmetic Surgery  
\_\_\_% Non-Surgical Pain Management (describe) \_\_\_\_\_  
\_\_\_% Research or Experimental (describe) \_\_\_\_\_  
\_\_\_% Other Surgery or Experimental (describe) \_\_\_\_\_

5. During administration of all anesthetics, do you use a pulse oximeter monitor? .....[  Yes [  No  
If No, explain. \_\_\_\_\_

6. During all anesthetics,

- (a) Is an electrocardiogram continuously displayed? .....[  Yes [  No  
If No, explain. \_\_\_\_\_
- (b) How often is arterial blood pressure determined and evaluated? \_\_\_\_\_
- (c) How often is heart rate determined and evaluated? \_\_\_\_\_
- (d) How is circulatory function evaluated? \_\_\_\_\_

7. During all general anesthesia, do you use an end tidal CO2 monitor? .....[  Yes [  No  
If No, explain. \_\_\_\_\_

8. During all general anesthesia using an anesthesia machine, do you:

- (a) Use an oxygen analyzer with a low concentration limit alarm? .....[  Yes [  No  
If No, explain. \_\_\_\_\_
- (b) Test proper functioning of alarms prior to each use? .....[  Yes [  No  
If No, explain. \_\_\_\_\_

9. When ventilation is controlled by a mechanical ventilator, do you:

- (a) Use a device equipped with a full set of safety alarms? .....[  Yes [  No  
If No, explain. \_\_\_\_\_
- (b) Test proper functioning of alarms prior to each use? .....[  Yes [  No  
If No, explain. \_\_\_\_\_

10. Are you present in the operating room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care? .....[  Yes [  No  
If No, explain. \_\_\_\_\_

11. Provide the following:

	<u>Weekly</u>	<u>Annually</u>
(a) Average number of patients you saw during the last 12 months for all jobs.	_____	_____
(b) Estimated number of patients you will see during the next 12 months for all jobs.	_____	_____
(c) Estimated number of patients you will see during the next 12 months for all jobs for which coverage is requested.	_____	_____

12. Provide the following (exclude on-call hours):
- (a) Your average number of weekly practice hours for all jobs. \_\_\_\_\_
- (b) Your average number of weekly practice hours for all jobs for which coverage is requested? \_\_\_\_\_
13. What is your gross annual revenue from your practice for this year? \$\_\_\_\_\_ Estimate for next year? \$\_\_\_\_\_
14. Do you employ anyone?.....[  Yes [  No  
If Yes,
- (a) Indicate by profession the number of individuals you employ:  
 \_\_\_ Nurse Anesthetists      \_\_\_ Other Professionals (describe) \_\_\_\_\_  
 Provide a detailed explanation of the responsibilities for each profession, including the extent supervised.  
 \_\_\_\_\_
- (b) Are all of the above individuals licensed in accordance with applicable state and federal regulations?  
 .....[  Yes [  No  
 If No, attach as detailed explanation.
- (c) Attach protocols and Certificate of Insurance for Professional Liability Insurance for all individuals you employ.
15. Do you supervise anyone other than your own employees? .....[  Yes [  No  
 If Yes, indicate by profession the number of individuals you supervise:  
 \_\_\_ Nurse Anesthetists      \_\_\_ Other Professionals (describe) \_\_\_\_\_  
 Provide a detailed explanation of the responsibilities for each profession and your relationship to the entity that employs these individuals. \_\_\_\_\_

16. List your prior Professional Liability Insurance for each of the last five (5) years, including the current year:

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date*
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

\* Attach a copy of the Declarations page from your current policy.

17. Do you currently participate in or plan to participate in a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism?..... [  Yes [  No  
 If Yes, identify. \_\_\_\_\_
18. Do you anticipate any changes in your practice in the next year? ..... [  Yes [  No  
 If Yes, attach a detailed explanation.

**IV. CLAIMS AND HISTORY**

1. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance? .....[  Yes [  No  
 If Yes, how many? \_\_\_\_\_ Complete a copy of our Supplemental Claim form for each one.
2. Has any claim or suit for malpractice ever been made against you or any entity proposed for this insurance that has not been reported to the current insurer or any prior insurer? .....[  Yes [  No  
 If Yes, how many? \_\_\_\_\_ Complete a copy of our Supplemental Claim form for each one.

3. Are you or any entity proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? .....[  Yes [  No  
If Yes, how many? \_\_\_\_\_ Complete a copy of our Supplemental Claim form for each one.
4. Have you ever been investigated, asked to resign or been involved in official or non-official proceedings brought by an employer, contractor, hospital, managed care organization or other organization to deny, limit, suspend, non-renew or revoke your privileges, employment or ability to practice? .....[  Yes [  No  
If Yes, attach complete copies of all official documents issued by the organization which address the allegations, the findings, and the outcome.
5. Has your license to practice nursing or your permit to prescribe or dispense drugs ever been limited, suspended, revoked, placed on probation or been voluntarily surrendered in any state? .....[  Yes [  No  
If Yes, attach complete copies of all documents issued by the licensing authorities involved in each investigation, restriction, suspension, revocation, probation or termination.
6. Have you ever been notified to respond to, appear before or have you ever been investigated by any licensing or regulatory agency on a complaint of any nature, including but not limited to unprofessional or unethical conduct? .....[  Yes [  No  
If Yes, attach complete copies of all documents issued by the licensing authorities involved in each investigation.
7. Have you ever been charged with or convicted of an act committed in violation of any law or ordinance? .....[  Yes [  No  
If Yes, attach a detailed summary of the circumstances, charges, jurisdiction, dates and current status/ outcome of each, and complete copies of any documents issued by police or judicial authorities which confirm your current status or outcome.
8. Have you ever been evaluated, treated or hospitalized for alcohol or substance abuse or mental or emotional disorders? .....[  Yes [  No  
If Yes, attach a detailed summary of your diagnosis, treatment dates and locations, treating physicians, current status and copies of any licensing board or hospital documents related to your status.
9. Have you ever had or do you now have a physical or mental disability or other condition or circumstance that, despite reasonable accommodation, would limit your ability to safely practice in your medical specialty? .....[  Yes [  No  
If Yes, attach a detailed summary of your status.

**Note: If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy, if issued.**

**NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY**

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Optional Extension Period option is exercised in accordance with the terms of the policy.

The underwriting manager, Company and/or affiliates thereof are authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which the underwriting manager, Company and/or affiliates thereof receives notice is on file with the underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the underwriting manager, Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

**WARRANTY**

I warrant to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

