If previously covered with Medical Protective or MedPro RRG Risk Retention Group, please enter the policy number: ____________________

MedPro RRG
Risk Retention Group

PHYSICIAN ENTITY (CORPORATION/PARTNERSHIP) PROFESSIONAL LIABILITY INSURANCE APPLICATION

Application Instructions

A. If additional space is needed, please complete Section VIII. Supplemental Information with a reference to the question.

B. For coverage to exist you must make separate application for any ancillary activity conducted by any separate entity, including any professional corporation, professional association, limited liability company, business corporation, partnership or joint venture. Additional documentation pertaining to the entity's existence and operations may be requested by the Company as necessary. For example: Articles of Incorporation, Declaration Page, copy of your most recent entity professional liability policy (including all endorsements), etc.

C. Please print legibly. Please answer all questions; if a question is not applicable, state "N/A".

D. A signed Subscriber Agreement and Power of Attorney must accompany this application.

I. Organization Information

A. Names: (As stated in the Articles of Incorporation and all formal entity/clinic names. Please provide Articles of Incorporation to ensure accurate coverage.)

Entity Name(s): ____________________

DBA, Fictitious Name, etc.: ____________________

_____ - ____________ Federal Tax I.D. Number

____________ National Provider Identifier Number

Date Entity Formed: _____ / _______ (MM YYYY)

Contact's Last Name: ____________ Contact's First Name: ____________

Contact's Title: ____________________

Email address: ____________________

Business Phone: _____ - _____ - _______ Business Fax: _____ - _____ - _______

B. If the above entity does business under any other name, please list all additional entity/clinic names.

Entity Name(s): ____________________

_____ - ____________ Federal Tax I.D. Number

____________ National Provider Identifier Number

Date Entity Formed: _____ / _______ (MM YYYY)

C. If you have a web address, please provide the website address (URL): ____________________

D. Type of Legal Entity: (Please enter an "X" in the applicable spaces. At least one type must be selected.)

- ☐ Professional Corporation - sole shareholder
- ☐ Professional Corporation - multiple shareholders
- ☐ Partnership or Professional Association
- ☐ Joint Venture
- ☐ Limited Liability Company (LLC) or Limited Liability Partnership (LLP)
- ☐ General Business Corporation
- ☐ For Profit
- ☐ Not for Profit
- ☐ Other (please explain): ____________________

E. Type of Organization/Business Practices: (Please enter an "X" in the applicable spaces. At least one type must be selected.)

- ☐ Abortions
  - ☐ Therapeutic - Number Per Year: ________
  - ☐ Elective - Number Per Year: ________
- ☐ AIDS/ARC
- ☐ Alternative Medicine (Integrative/Complimentary)
- ☐ Anesthesia
- ☐ Bariatrics
- ☐ Behavioral Health Facility/Psychiatric Facility
- ☐ Blood Banks
- ☐ Cancer Treatment Center
- ☐ Clinical Trials
- ☐ Community Based Health Center
- ☐ Cosmetic Surgery
- ☐ Dental
- ☐ Dialysis Center
- ☐ Emergency
- ☐ Experimental Surgery
- ☐ General Hospital
- ☐ Home Health Care
- ☐ Hospice
- ☐ Hospital - Industrial
- ☐ In Vitro Fertilization
- ☐ Laboratory
- ☐ Liposuction
- ☐ Managed Care Organization/ Managed Services Organization
- ☐ Medi-Spa
- ☐ MRI/X-Ray/Imaging
- ☐ Nursing Home
- ☐ Obstetrics
- ☐ Osteopathic Manipulation Therapy
- ☐ Pathology
- ☐ Pharmacy
- ☐ Physical Therapy Center
- ☐ Plastic Surgery
- ☐ Radiation Therapy
- ☐ Sports Medicine
- ☐ Standard Medical Practice
- ☐ State/County Health Department
- ☐ Substance Abuse Center
- ☐ Surgical Center
- ☐ Telemedicine
- ☐ University/Teaching Facility
- ☐ Urgent Care
- ☐ Weight Reduction
- ☐ Wound Care
- ☐ Other (please explain): ____________________

I. Organization Information (continued)

F. Is this entity associated with a current MedPro RRG Risk Retention Group insured? ☐ Yes ☐ No

If yes, please provide MedPro RRG Risk Retention Group policy or group number, if known.

Policy#: ________ Group#: ________

G. Practice Location(s): (Please list primary location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

1. ________ **% of practice**

Number & Street ________

Suite ________ City ________ State ________ Zip Code ________ - ________

County ________

2. ________ **% of practice**

Number & Street ________

Suite ________ City ________ State ________ Zip Code ________ - ________

County ________

3. ________ **% of practice**

Number & Street ________

Suite ________ City ________ State ________ Zip Code ________ - ________

County ________

H. Billing and Correspondence Address:

☐ Location # (from Question G above): ________ ☐ Other (Please enter below)

Number & Street ________ Suite ________

City ________ State ________ Zip Code ________ - ________

I. In which state(s) is this entity authorized to do business?

State of Incorporation: ________ Certificate(s) of Authority: ____ , ____ , ____ , ____ , ____ , ____ , ____ , ____

II. General Information

A. Has your entity or any of your employees:

1. Ever been the subject of disciplinary investigative proceedings or a reprimand by a governmental licensure board or administrative agency, hospital or professional association? ☐ Yes ☐ No

   If yes, please provide individual(s) involved, date and explanation.

   Individual(s): ________ Date: ____ / ____ (MM / YYYY)

   Explanation: ________

2. Ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance, other than traffic offenses, or had hospital privileges, DEA license, medical license, or Medicaid/Medicare privileges revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? ☐ Yes ☐ No

   If yes, please provide individual(s) involved, date and explanation.

   Individual(s): ________ Date: ____ / ____ (MM / YYYY)

   Explanation: ________

3. Ever had any professional liability insurance refused, declined, canceled or non-renewed by the insurance company? ☐ Yes ☐ No

   If yes, please provide individual(s) involved, date and explanation.

   Individual(s): ________ Date: ____ / ____ (MM / YYYY)

   Explanation: ________

II. General Information (continued)

B. Does the entity own or operate any laboratory? ☐ Yes ☐ No

If yes, is the laboratory providing services solely for your patients? ☐ Yes ☐ No

If no, please explain: ____________________

C. Will the entity be performing activities which will be covered by another professional liability policy? ☐ Yes ☐ No

If yes, state practice name, location and insurer name.

Practice Name: ____________________

Location: ____________________

Name of Insurer: ____________________

D. Has the entity performed any contract work for or entered into any contract or agreement (written or oral) with any entity/city/county/state/federal agency/clinic including providing care at correctional facilities, prisons, mental health facilities, Veteran's Administration, university, military or indigent care, etc.? ☐ Yes ☐ No

If yes, please explain: ____________________

E. Please include estimated annual numbers:

Clinic visits: __________

Surgeries: __________

Gross Revenue: $ ______ , ______ , ______

F. In the last 10 years:

1. Has the entity or any of the employees discontinued major surgical procedures, performance of Obstetrics, or any other medical activity? ☐ Yes ☐ No

   If yes, list procedures/activities, reason for discontinuing, and date discontinued. Date: ____ / ______ (MM / YYYY)

2. Have any of the employees performed weight control surgery or prescribed weight control medication? ☐ Yes ☐ No

   a. If yes, what percentage of the practice (% of patient care) was devoted to prescribing anorectic drugs?
   ☐ <1% ☐ 1% - 10% ☐ 11% - 50% ☐ > 50% ☐ Never prescribed anorectic drugs

   b. If yes, what percentage of the practice (% of patient care) was devoted to performing weight control surgery?
   ☐ <1% ☐ 1% - 10% ☐ 11% - 50% ☐ > 50% ☐ Never performed weight control surgery

G. Does the entity or any of the physicians have ownership or financial interests in a weight control clinic? ☐ Yes ☐ No

If yes, what is the name of the weight control clinic with which the entity or physicians are affiliated? ____________________

III. Anesthesia Information

A. As defined below, please enter an "X" if a shareholder/partner, employee or independent contractor treats patients under:

☐ **Conscious Sedation (excluding Nitrous Oxide)** utilizing a minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

☐ Oral ☐ IM/IV

☐ **General Anesthesia (to include deep sedation)** utilizing a controlled state of depressed consciousness or unconsciousness, accompanied by partial or completed loss of protective reflexes, including inability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method, or a combination thereof.

If Conscious Sedation or General Anesthesia was checked, please complete the Anesthesia Supplement.

B. ☐ **Please "X" here if this section does not apply to you. Checking this box indicates your practice limits administration of anesthesia to local, oral (chloral hydrate or similar), or nitrous oxide only. Please continue to Section IV.**

IV. Roster of Staffing

A. Please identify all owners, employed and contracted individuals within your organization, and provide information concerning each member in each category listed in the following table:

Note: Include all applicant(s), all healthcare provider(s), and non-healthcare owner(s).

Individual Status: (Column 5)

A. Requesting Individual MedPro RRG Risk Retention Group coverage.
B. Current Individual MedPro RRG Risk Retention Group insured.
C. Applying for coverage elsewhere or covered elsewhere.
D. Shared Limit Coverage with entity for Healthcare Professionals, other than physicians or dentists, with MedPro RRG Risk Retention Group.
E. Other.

	1. Last name first, then first and middle initials (i.e. Smith, J. G.)	2. Degree	3. Specialty (Write In)	4. (S) Shareholder (P) Partner (E) Employee (IC) Independent Contractor	5. Individual Status- A,B,C, D, or E (See key above)	6. MedPro RRG Risk Retention Group Policy Number
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						

B. Please provide an explanation as to why coverage is not requested for any individuals where Individual Status is C on Roster.

Number from Roster: **Explanation:**

_____ ____

_____ ____

_____ ____

_____ ____

_____ ____

V. Loss Information

Please complete the Loss Information Supplement for each written request, incident, claim or suit (A, B or C) below in which the entity's policy was triggered and has NOT been covered by a MedPro RRG Risk Retention Group policy.

Report professional liability and malpractice related matters including, but not limited to, board complaints, etc.

For Questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Is your entity involved now or has it ever been involved in a claim or suit arising out of the rendering or failure to render professional services?

If **yes**, how many? ________ None ☐

B. Is your entity aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit? This includes, but is not limited to, the following:

► Amputation ► Death ► Loss of major organ function ► Loss of vision ► Permanent neurological injury

If **yes**, how many? ________ None ☐

C. In the last 12 months, has your entity received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit?

If **yes**, how many? ________ None ☐

VI. Coverage Information

Notes:

1. **Claims-Made coverage is generally limited to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between Claims-Made and Occurrence coverage or the additional expense associated with "extension contract" or "tail coverage".**
2. **Requested limits and/or policy types may not be available in all states.**

A. Coverage Desired:

☐ Claims-Made coverage without Prior Acts coverage ☐ Occurrence coverage
☐ Claims-Made coverage with Prior Acts coverage

B. Requested Coverage Period (12:01 am): **From:** ____ / ____ / ______ (MM DD YYYY) **To:** ____ / ____ / ______ (MM DD YYYY)
Annual policy term will begin and end on the same month and day.

C. The retroactive date shown on your current Claims-Made policy is: ____ / ____ / ______ (MM DD YYYY)
(This date is required for Claims-Made with Prior Acts.)

D. Desired Limits: Per Occurrence/Per Claim Filed ______ , ______ , ______ Annual Aggregate ______ , ______ , ______

E. List all previous professional liability insurers within the past 10 years. If your requested retroactive date is greater than 10 years, provide previous insurers back to your requested retroactive date.

1. Current Insurer: ______________________________

☐ Occurrence ☐ Claims Made From: ____ / ____ / ______ (MM DD YYYY) To: ____ / ____ / ______ (MM DD YYYY)

2. Previous Insurer: ______________________________

☐ Occurrence ☐ Claims Made From: ____ / ____ / ______ (MM DD YYYY) To: ____ / ____ / ______ (MM DD YYYY)

3. Previous Insurer: ______________________________

☐ Occurrence ☐ Claims Made From: ____ / ____ / ______ (MM DD YYYY) To: ____ / ____ / ______ (MM DD YYYY)

F. If "Occurrence" or "Claims-Made Without Prior Acts" was selected as the desired coverage and the most recent prior coverage was issued on a Claims-Made basis, please complete the following:

☐ An extended reporting endorsement (tail coverage) has been or will be purchased.
☐ An extended reporting endorsement has not and will not be purchased.

I will not purchase tail coverage (reporting endorsement) from my current carrier where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current carrier will result in an uninsured exposure for any claims which may arise as a result of professional services rendered while insured by my current carrier's policy. I understand that the policy, which I am applying from MedPro RRG Risk Retention Group, will not provide Prior Acts coverage.

Initial Here

VII. Notices and Agreements

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments **(hereinafter "Attachments")** for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any **Attachments,** shall be the basis of the contract with MedPro RRG Risk Retention Group (the "Company"). I agree to notify the Company if there are any future material changes in any answer to this application, or its **Attachments,** including without limitation, any change in my professional specialty, affiliation or working arrangement with any other dentist, physician, firm or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and void and without effect or provide the Company the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until MedPro RRG Risk Retention Group has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if MedPro RRG Risk Retention Group has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by MedPro RRG Risk Retention Group until it has been honored by the bank.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.

I also understand that MedPro RRG Risk Retention Group may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to MedPro RRG Risk Retention Group any information regarding me, which MedPro RRG Risk Retention Group, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

I warrant that I am authorized to disclose all information that I may submit or which I may authorize others to submit in connection with this application, including authority to disclose such information under federal and state privacy protection statutes and regulations.

By signing this application on behalf of an entity (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity), I warrant that I am an Officer, Partner, Office Administrator or other Authorized Representative of the entity applying for coverage.

Application must be signed by a President, Chief Executive Office, or other Officer or Partner of a PC or PA or the Office Administrator or equivalent Authorized Representative.

______________________________ Date Signed: ____ / ____ / ________
Authorized Representative Signature MM DD YYYY

____
Print Name

VIII. Supplemental Information

MEDPRO RRG Risk Retention Group
Subscriber Agreement and Power of Attorney

WHEREAS, the undersigned subscriber ("Subscriber") acknowledges and agrees that this Subscriber Agreement and Power of Attorney ("Subscriber Agreement") (along with other subscriber agreements) constitute the charter of MEDPRO RRG Risk Retention Group ("MEDPRO RRG") and that the subscribers to MEDPRO RRG from time to time shall together comprise the reciprocal insurer, which shall operate through its Attorney-in-Fact as provided in this Subscriber Agreement as a risk retention group in accordance with federal law and as a risk retention group in the form of a reciprocal captive insurer in accordance with District of Columbia law.

NOW THEREFORE, in consideration of similar agreements executed or to be executed by other subscribers and of the benefits of the exchange of such agreements and of the terms of this Subscriber Agreement, the Subscriber agrees to the following terms and conditions.

1. **Appointment and Powers and Duties of Attorney-in-Fact.**
Appointment and Powers and Duties of Attorney-in-Fact. Subscriber agrees to the appointment of MedPro Risk Retention Services, Inc., an Indiana corporation ("Attorney-in-Fact"), as the Attorney-in-Fact for MEDPRO RRG to carry out the purposes and objectives set forth in this Subscriber Agreement and to carry out all business on behalf of MEDPRO RRG and the subscribers thereto. Attorney-in-Fact is vested with all necessary power and authority to act on behalf of MEDPRO RRG and the subscribers thereto, including conducting the affairs of MEDPRO RRG, managing and operating (directly or through contract with third parties (including affiliates of Attorney-in-Fact)) MEDPRO RRG for the benefit of the subscribers, and causing the issuance and exchange of indemnity, insurance or reinsurance contracts with other subscribers.

2. **Limitations of Liability.**
a. The financial liability of Subscriber shall be limited to the amount of annual premiums on any contracts of indemnity, insurance or reinsurance due from Subscriber, provided, however, that all contracts of indemnity, insurance or reinsurance shall contain a "limit of liability" and in the event it is determined that Subscriber's liability on a claim under said contract of indemnity, insurance or reinsurance exceeds the limit of liability, such excess amount shall be the sole and complete responsibility of Subscriber.

b. Should any suit, legal proceeding or other action be brought against Attorney-in-Fact resulting from or arising out of Subscriber's obligation on any contract of indemnity, insurance or reinsurance that Subscriber may enter into, then and in that event, any and all judgments entered against Attorney-in-Fact in that capacity shall be deemed a legal judgment against Subscriber.

3. **Maintenance and Distribution of Surplus.**

Attorney-in-Fact shall cause MEDPRO RRG to maintain surplus in an amount sufficient to provide for the financial integrity of MEDPRO RRG and in an amount satisfactory to the District of Columbia Department of Insurance, Securities and Banking. In no event, however, shall Attorney-in-Fact be required to contribute its own assets or the assets of any affiliate to MEDPRO RRG.

a. Subscriber authorizes Attorney-in-Fact to accrue for the benefit of MEDPRO RRG and the subscribers net income and savings realized from the exchange of contracts of indemnity, insurance or reinsurance hereunder and the management of MEDPRO RRG and its assets.

b. Subject to the laws of the District of Columbia, if MEDPRO RRG is dissolved by Attorney-in-Fact, Attorney-in-Fact shall, after the full satisfaction of all liabilities and surplus notes of MEDPRO RRG from MEDPRO RRG's assets, pay each subscriber then insured an equitable share of all remaining assets, which payment shall be in full satisfaction of all rights and interests of such subscribers. Amounts to be paid to subscribers shall be distributed on an equitable basis as determined by Attorney-in-Fact.

4. **Term of Subscriber Agreement**.

a. This Subscriber Agreement shall have no fixed term and begins with the commencement of the policy period of any contract of indemnity, insurance or reinsurance issued hereunder to Subscriber and ends upon cancellation or other termination of such contract of indemnity, insurance or reinsurance or upon replacement of this Subscriber Agreement by a modified subscriber agreement provided by Attorney-in-Fact. The period of subscription shall not include any period of coverage under extended reporting policies or extended reporting or tail coverage endorsements.

b. Subscriber agrees that this Subscriber Agreement is expressly limited to the uses and purposes herein expressed and to no other. This Subscriber Agreement may be terminated by Subscriber or by Attorney-in-Fact upon 30 days written notice. The Subscriber's appointment of Attorney-in-Fact and Subscriber's obligations and authorizations under this Subscriber Agreement shall survive the termination of this Subscriber Agreement until any and all claims involving the indemnity, insurance or reinsurance contracts of the Subscriber and any and all other matters existing between the Subscriber and MEDPRO RRG, the Attorney-in-Fact or with third parties have been settled or satisfied. Subscriber agrees that the Attorney-in-Fact shall have the authority and ability to perform all duties and carry out all obligations during any extended reporting or tail coverage endorsements during the term of this Subscriber Agreement or after termination.

c. After termination of this Subscriber Agreement, Subscriber shall have no rights to participate in any distribution of assets upon dissolution of MEDPRO RRG.

5. **Replacement of Attorney-in-Fact**.

Attorney-in-Fact may resign as Attorney-in-Fact upon designation by Attorney-in-Fact of a successor attorney-in-fact and 60 days written notice to existing subscribers. Any such successor attorney-in-fact shall have all the powers, rights and duties provided for in this Subscriber Agreement, and this Subscriber Agreement shall remain in full force and effect with such successor attorney-in-fact.

6. **Principal Office**.

The principal office of MEDPRO RRG shall be maintained in the District of Columbia or at such other place as designated by Attorney-in-Fact.

7. **Limitation of Liability of Attorney-in-Fact**.

Subscriber agrees that no officer, director, or employee of Attorney-in-Fact shall be personally liable to MEDPRO RRG or its subscribers for any breach of duty owed to MEDPRO RRG or its subscribers, provided however that this provision shall not relieve an officer, director or employee from liability for any breach of duty based on an act or omission (a) in breach of such person's duty of loyalty to MEDPRO RRG and its subscribers; (b) not done in good faith or involving a knowing violation of law; or (c) resulting in receipt by such person of an improper personal benefit. Such officers, directors and employees of Attorney-in-Fact shall be entitled to indemnification and advancement of expenses subject to the same exceptions recited above.

8. **Nature of MEDPRO RRG**.

Subscriber acknowledges that MEDPRO RRG is a risk retention group organized in the District of Columbia as a reciprocal captive insurer and as such its contracts of indemnity, insurance or reinsurance are not subject to all state insurance laws and regulations. Further, state insolvency or guarantee funds are not available to risk retention groups, like MEDPRO RRG. Subscriber also acknowledges that MEDPRO RRG is a reciprocal organization under which each subscriber exchanges insurance obligations with the other subscribers through an attorney-in-fact.

9. **Governing Law**.

This Subscriber Agreement shall be governed by and interpreted according to the laws of the District of Columbia without giving effect to the conflict or choice of law provisions of that or any other jurisdiction.

Subscriber Signature

IN WITNESS WHEREOF, the Subscriber has caused this Subscriber Agreement to be executed individually or by its duly authorized officer, as applicable, as of the __ day of __________, 20__.

SUBSCRIBER

By ______________________________

Date: ______________________________ ______________________________

Name and Title

Acceptance

MedPro Risk Retention Services, Inc., an Indiana corporation, Attorney-in-Fact for MEDPRO RRG Risk Retention Group, hereby accepts this Subscriber Agreement from Subscriber.

ATTORNEY-IN-FACT

By

Trent Heinemeyer – Vice President and Secretary

Anesthesia Supplement

Please make copies if additional forms are needed.

Applicant's Name: ______________________

A. Number of: **Anesthesiologists** _____ **CRNAs** _____

B. Other than Anesthesiologists or CRNAs, list anyone who administers anesthesia or conscious sedation:

____

____

____

C. Are all the CRNAs supervised on site by an anesthesiologist? ☐ Yes ☐ No

D. Is the anesthesia provider currently licensed in your state? ☐ Yes ☐ No

If no, please explain: ______________________

E. Are all individuals who administer the sedation certified in one or more of the following? ☐ Yes ☐ No

☐ CPR ☐ ACLS ☐ ATLS ☐ PALS

If no, please explain: ______________________

F. Are all Anesthesiologists required to be board-certified/eligible in Anesthesiology? ☐ Yes ☐ No

G. Please indicate who administers conscious sedation?

☐ MD/DO ☐ RN/LPN
☐ AA/NA/CRNA ☐ Other (specify): _________

Where is conscious sedation performed?

☐ Office ☐ Licensed Surgical Center
☐ Hospital ☐ Other (specify): _________

For:

☐ Own Patients
☐ Other than own patients

H. Please indicate who administers general anesthesia?

☐ MD/DO ☐ RN/LPN
☐ AA/NA/CRNA ☐ Other (specify): _________

Where is general anesthesia performed?

☐ Office ☐ Licensed Surgical Center
☐ Hospital ☐ Other (specify): _________

For:

☐ Own Patients
☐ Other than own patients

I. Is the office certified for general anesthesia by a state organization? ☐ Yes ☐ No

If administered outside of a hospital or a licensed surgery center, please answer Questions J through P.

J. How often does your staff participate in simulated emergency training?

Every: ☐ 3 months ☐ 6 months ☐ 12 months ☐ Other: ______________

K. What American Society of Anesthesiology (ASA) categories are treated? ______________

L. How often does your practice update health histories?

☐ Every _____ Month(s) ☐ Every patient visit ☐ Anytime invasive procedures are performed

M. Is a pre-anesthesia evaluation done by an anesthesiologist? ☐ Yes ☐ No

N. Is there a separate informed consent for anesthesia? ☐ Yes ☐ No

O. Please place an "X" next to the equipment utilized.

☐ Fail safe mechanisms on anesthesia machines
☐ Basic Airway Equipment
☐ Face Mask Resuscitator
☐ Oral and Nasopharyngeal Airways
☐ Endotrachael Tubes (Adult/Child size)
☐ Laryngoscopes

☐ Sphygmomanometer/Stethoscope
☐ Electrocardiographic Monitoring Equipment
☐ Pulse Oximeter
☐ CO2 Detector
☐ Internal/External Temperature Monitor
☐ Tracheostomy/Crycothyrotomy Equipment

☐ Portable Suction
☐ Capnography
☐ Auxiliary Lighting
☐ Emergency Pharmaceutical Kit
☐ Cardiac Defibrillator
☐ Emergency Tube Thoracostomy Equipment

If you do not utilize any of the above equipment, please explain: ______________________

____

1. Who owns and maintains the oxygen equipment? ______________________
2. Do you monitor the use of reversal agents? ☐ Yes ☐ No

P. Do you treat children? ☐ Yes ☐ No

Loss Information Supplement

Please make copies if additional forms are needed.

Applicant's Name: ____________________

Note: Additional documentation may be requested at The MedPro RRG Risk Retention Group's discretion.

A. Is the matter related to: **A** ☐ **B** ☐ **C** ☐ **from the Loss Information section? (Check only one)**

A. Current or prior claim.

B. Complication, incident, or adverse outcome.

C. Written request for records.

B. Patient/Claimant Information:

Last Name ____________________ First Name ____________________ Age ______

C. Date of treatment and/or surgery which led, or could lead, to allegations against you. ____ / ______ (MM / YYYY)

D. Date of notice received, if applicable. ____ / ______ (MM / YYYY)

E. Has this matter been reported to your current or former insurer? ☐ Yes ☐ No

If yes, date reported to your current or former insurer: ____ / ______ (MM / YYYY)

Current or former insurer name: ____________________

If no, please explain: ____________________

F. Name of all other doctor(s), hospital(s), or health care provider(s), if any, involved. ____________________

G. Current status: ☐ Open ☐ Closed

If open, indicate dollar value established by insurer: $ ____________________

If closed:

1. Date of closing: ____ / ______ (MM / YYYY)
2. Was a payment made? ☐ Yes ☐ No
   - a. If yes, did you consent to the settlement? ☐ Yes ☐ No
   - b. Total amount of settlement or award: $ ____________________
   - c. Total amount of settlement or award paid on your behalf: $ ____________________

H. Nature of allegations or potential allegations:

Condition Treated: ____________________

Treatment Provided: ____________________

Alleged Negligence: ____________________

Alleged Injury: ____________________

I. Please provide a narrative description of all relevant facts, including, but not limited to, your involvement in the treatment and/or surgery:

____