# PHYSICIANS AND PSYCHIATRISTS LIABILITY QUESTIONNAIRE

INSTRUCTIONS: **The Physicians and Psychiatrists Liability Questionnaire must be completed for each physician and psychiatrist.** Please complete the entire form. 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 you to the Social Service Agency's professional insurance coverage.

| **FOR OFFICE USE ONLY – Please do not complete.** | |
|---|---|
| ☐ **United National Insurance Company** | ☐ **Diamond State Insurance Company** |
| ☐ **United National Specialty Insurance Company** | ☐ **United National Casualty Insurance Company** |

1. Your Name ______________________________ Agency Name ______________________________
2. Medical Specialty______________________________ Are you Board Certified? Yes___ No___
3. License Number/State ______________________________
4. 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)**
5. What is your working relationship with the Clinic Center? Employee___ Contractor___ Volunteer___
6. Hours per week you work on behalf of the Agency? ________ How many weeks per year? ________
7. List the responsibilities/duties you perform for the Agency (please be specific).

   ______________________________________________________________

   ______________________________________________________________

   ______________________________________________________________

8. Do you or will you perform any of the following medical procedures or services on behalf of the Agency? 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 | ______ | ______ |

9. Do you provide any other medical procedures or service on behalf of the agency? Yes___ No___
   If yes, please describe below:

   ______________________________________________________________

   ______________________________________________________________

10. Do you obtain consent to treat patients? Yes___ No___

11. 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 of the claim or allegation.)**

15. Have you ever had your medical license revoked, suspended, restricted or placed on probation? Yes___ No___

16. Have you ever been the subject of an investigation, disciplinary proceeding or reprimand? Yes___ No___

17. Have you ever been convicted of a crime or felony? Yes___ No___

18. Have you ever been treated for alcoholism or drug addiction? Yes___ No___

19. Do you have a private practice or provide services for any other agency or institution? Yes___ No___

If yes, please provide the details of your professional liability carrier(s) in the table below:

| Insurance Company | Policy Term | Retro Date, if Claims Made | Policy Limits | Premium |
|---|---|---|---|---|
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20. Do any of the policies above extend to cover you for your acts at this Agency? Yes___ No___

I declare that the information contained in this application is true to the best of my knowledge and that no material facts have been suppressed or misstated. I understand that a material suppression of facts concerning the operations of the organization could void my coverage or result in a cancellation of coverage.

_______________________________ ______/______/______
Physician's Signature Date

_______________________________ ______/______/______
Signature of Applicant Date

_______________________________
Name and Title