Professional Liability Application for Medical Directors

1. Name of Applicant: _____

2. Mailing Address: _____

3. Telephone Number: _____

4. Exposure: Please complete the table below showing the exposure with regards to the organization(s) where Medical Director services are provided.

Name of Organization	Address of Organization	Type of Organization	Hours per week providing Medical Director services

Please attach a copy of contract between Medical Director & organization describing the duties & responsibilities of the Medical Director and a copy of the Medical Director's resume showing training & experience.

5. Does the applicant also have direct patient care at any of the above organizations or locations, or could they be called upon to act within their capacity as a physician to treat, intervene in the treatment, direct the treatment or consult in the treatment of any patient/client?

Yes ☐ No ☐

If yes, please provide details including at which location(s), how often such circumstances occur and attach proof of coverage elsewhere for this exposure:

_____

_____

6. Please complete the table below showing the applicant's Medical Director coverage for last 5 years:
(if none, state none)

Carrier	Limit	Deductible	Premium	Expiration Date	Retro Date (if applicable)

Carrier	Limit	Deductible	Premium	Expiration Date	Retro Date (if applicable)

7. Has the applicant or have any of their employees (please attach a detailed explanation for any "yes" answers):

	Yes	No
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?		
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?		
c) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?		
d) Ever had an application for Professional Liability Insurance made on their behalf which has been declined or has their insurance ever been cancelled or renewal refused?		

8. Has any medical malpractice claim ever been made against you? Yes ☐ No ☐
If yes, please attach completed claims supplement.

9. Has any claim ever been made against you with regards to services provided as Medical Director?

Yes ☐ No ☐ **If yes, please attach completed claims supplement.**

10. Is the applicant aware of any circumstances which may result in any claim?

Yes ☐ No ☐ **If yes, please attach completed claims supplement.**

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

(NOTE: Application must be signed by the owner or president or principal)