MarketScout

MEDICAL DIRECTOR
PROFESSIONAL LIABILITY APPLICATION
(CLAIMS MADE AND REPORTED BASIS)

Please email application to healthcare@marketscout.com

Effective date desired:_____

1. Physician name : _____

   Address: _____

   City: _____ State:_____ Zip:_____ County:

   Phone: _____ _____ Fax: _____

2. Type of organization, service or facility where applicant provides services as Medical Director_____

   _____

   Name of Organization:_____

   Address:_____

3. Telephone Number office_____ Fax:_____

4. Extent of operations (size) of organization, service of facility, for which these units of exposure are applicable:

   No. of Ambulances_____No. of Outpatient Visits _____No of beds: _____

   Organization/ services/ facility's annual receipts (or operating budget): _____

   _____

5. Medical Director duties/Contract: attached copy of contract between Medical director & organization and description of the duties and responsibilities of medical Director, if not included in contract.

6. Describe any circumstances wherein the applicant in his/her capacity as Medical director may also be called upon to act with his/her capacity as a "physician" to treat, intervene in the treatment, direct the treatment or consult in the treatment of any person (patient/client):_____

   _____

   How often might circumstances occur? _____

   Number of hours per month applicant will provide services as a medical Director:_____

7. Limit of Liability requested: $_____ per incident/$_____per aggregate

8. Proposed effective date:_____ No. Years as Medical director_____

Applicant Info (Physician):

License #:_____ Expiration date_____ State_____Year licensed:_____Certification:_____

9. Current Practice : _____ Dates from _____ to _____ _

10. Medical School: _____ Dated Completed_____ Degree_____
Internship/ Residencies: Medical Center _____ dates served:_____

11. Hospital Privileges(hospital name/ address & Nature of Privileges):_____

12. Medical Malpractice Insurance – attached certificate or other verification of current insurance.

13. Claims information: Has any claim or suit for alleged malpractice been brought against you in the last 5 years, or are you aware of circumstances that might lead to such a claim/suit? ❑ Yes ❑ No

If yes, provide full details. _____

14. Sanctions: Has application ever had his/her license or certification revoked, suspended, or restricted, been subject to any disciplinary proceeding, been reprimanded by an administrative agency, professional association or peer committee: ❑Yes ❑ No

Statement of non-conflict:

a. Applicant is NOT a principal, Proprietor, superintendent, office director, stockholder or member of the board of directors, trustees, or governors, of the organization named in Item 2 of this application nor is applicant in any other manor, except as Medical Director, Affiliated or associated with said organization.
b. No Patient or client of the organization named in item 5 of this application is billed or charged specially for services afforded by the applicant whether is his/her capacity as Medical Director, physician or otherwise.
EXCEPTIONS, if any to above (leave blank if no exceptions)_____
_____

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

_____/ _____

Applicant's Signature **Title** **Date**