LS-INSURANCE

# PSYCHIATRIST SUPPLEMENTAL APPLICATION

## A. GENERAL INFORMATION:

1. Name of Clinic/Center: _____
2. Do you serve as the Medical Director or Chief of Psychiatry at this location? ☐ Yes ☐ No
3. Do you teach at this location? ☐ Yes ☐ No

## B. PROFESSIONAL TRAINING:

1. List the professional societies of which you are a member: _____

   _____
2. License Number(s) and State(s): _____
3. Medical School Attended: _____ Country: _____

   Year Graduated: _____ Degree: _____
4. If you are a graduate of a non-US medical school, have you obtained an ECFMG Certificate? ☐ Yes ☐ No
5. Are you Board Certified in any of the following specialties?

| Yes | No | Specialty | Date Attained (mm/dd/yy) |
|---|---|---|---|
| ☐ | ☐ | General Psychiatry | |
| ☐ | ☐ | Child & Adolescent Psychiatry | |
| ☐ | ☐ | Geriatric Psychiatry | |
| ☐ | ☐ | Administrative Psychiatry | |
| ☐ | ☐ | Other (Specify): | |

6. a. How many hours per week do you spend in active practice for Clinic/Center? _____

   b. How many weeks per year do you spend in active practice for Clinic/Center? _____
7. a. Have you successfully completed psychoanalytic training? ☐ Yes ☐ No

   b. If Yes: Date attained: _____

   c. Average weekly # of total practice hours: _____

   d. Average weekly # of psychoanalytical hours: _____

## C. PRACTICE PROFILE: Please attach a separate sheet for any required explanations.

1. a. Do you sign insurance or other reimbursement forms for patients where you have not participated in their care and treatment? ☐ Yes ☐ No

   b. If Yes, please describe in what capacity (e.g., as a Medical Director) and indicate if you clarify what your signature means on such forms. _____

   _____

2. a. Do you create and maintain a psychiatric/medical record for each patient under your care? ☐ Yes ☐ No

   b. If No, please explain: _____

3. Do you prescribe controlled substances? ☐ Yes ☐ No

4. Do you obtain an informed consent, whether signed by patient or noted in chart, before prescribing, especially when prescribing neuroleptics? ☐ Yes ☐ No

5. a. Do you write prescriptions for patients you have not clinically evaluated other than to cover for another colleague whose patient requires a minimal refill on an existing prescription? ☐ Yes ☐ No

   b. If Yes, please explain under what circumstances: _____

6. a. Do you treat patients with unconventional therapy, i.e., treatment not considered to be mainstream psychiatric treatment? ☐ Yes ☐ No

   b. If Yes, please describe: _____

7. a. Do you perform electro-convulsive therapy for the center named above (ECT)? ☐ Yes ☐ No

   b. Where is this procedure performed? _____

   c, Is Anesthesia always administered in a licensed Medical facility? ☐ Yes ☐ No

   d. Who administers Anesthesia?
   ☐ Anesthesiologist ☐ CRNA ☐ Other: (explain): _____

## D. CLAIM INFORMATION

1. Have you ever been:

   a. The subject of an investigatory or disciplinary proceeding or reprimand? ☐ Yes ☐ No

   b. Have you been charged with, convicted of, or pleaded guilty or no contest to a felony? ☐ Yes ☐ No

   c. Treated for alcoholism or drug addiction? ☐ Yes ☐ No

2. Have you ever been, or are you currently, either sexually, romantically, or socially involved with any current, or former, patient or with a family member of a patient? ☐ Yes ☐ No

3. Have you ever had a settlement or judgment alleging undue familiarity, professional misconduct, or assault in connection with undue familiarity? ☐ Yes ☐ No

4. a. Have you ever had a malpractice claim or suit filed against you? ☐ Yes ☐ No

   b. If Yes, how many? _____

5. a. Do you know of any incident that may result in a claim against you? ☐ Yes ☐ No

   b. If Yes, for each claim, suit, or incident, complete a separate claim activity form.

## E. INSURANCE

1. a. Has any insurance company ever declined, failed to renew, conditionally renewed or cancelled a Professional Liability Policy for you? ☐ Yes ☐ No

   b. If Yes, please list company, date, and reason for the action by the company: _____

2. a. Apart from the insurance provided by your employer, do you carry your own professional liability insurance? ☐ Yes ☐ No

   b. If Yes, what is the name of your insurer? _____

   c. Policy Number: _____

   d. Policy Dates: _____ Limits: _____

3. a. Is coverage: ☐ Occurrence ☐ Claims Made

b. If Claims Made, what is retroactive date? _____

c. Does this malpractice policy cover you for your acts at the center? ☐ Yes ☐ No

**F. DECLARATION AND SIGNATURE:**

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

| | |
|---|---|
| Applicant's Signature | Sub-Producer |
| Title | Date |
| | Producer |

*SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPLETE THE INSURANCE. Application MUST be currently signed and dated to be considered for quotation.

**Submit**