



U.S. Risk Underwriters
a member company of U.S. Risk Insurance Group, Inc.

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**APPLICATION FOR
 CERTIFIED NURSE ANESTHETIST
 PROFESSIONAL LIABILITY INSURANCE**

(CLAIMS MADE AND REPORTED BASIS)

(PLEASE TYPE OR PRINT IN INK)

Requested Effective Date: _____

1. GENERAL INFORMATION:

a. Full Name of Applicant: _____

b. Principal Business Address: _____
 (Street)

 (City) (State) (Zip) (County)

Phone: _____ Fax: _____

E-Mail address: _____ Website address: _____

Date of Birth: _____ Place of Birth: _____

c. Applicant is:

- | | | |
|---|---|---|
| <input type="checkbox"/> Sole practitioner (unincorporated) | <input type="checkbox"/> Sole practitioner (incorporated) | <input type="checkbox"/> Free-lance locum tenens |
| <input type="checkbox"/> Employee of locum tenens company | <input type="checkbox"/> Professional Association | <input type="checkbox"/> Other |
| <input type="checkbox"/> Professional Corporation
(non-profit) | <input type="checkbox"/> Employee of _____
(give name of employer) | <input type="checkbox"/> Independent Contractor of
_____ |

d. Federal Tax ID Number: _____

e. What is your gross annual revenues from your practice for this year? \$ _____ Estimate for next year? _____

f. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?..... Yes No

If Yes,

(i) Has the Applicant implemented procedures to comply with the HIPPA Privacy Rule? Yes No

(ii) Provide the name and title of the Applicant's Privacy Officer: _____

2. PRACTICE:

a. Principal practice location for which coverage is requested:

 (Practice Name) (Street)

 (City) (Street) (ZIP)

(i) Provide the number of weekly hours for your principal practice location (exclude on-call hours) _____

(ii) Your principal practice location is a(n):

- [] Hospital [] Ambulatory Surgery Center [] Professional Office with Specialty

b. Secondary practice location for which coverage is requested. (If none, check here [])

(Practice Name)	(Street)	
(City)	(State)	(Zip)

- (i) Provide the number of weekly hours for your secondary practice location (exclude on-call hours). _____
- (ii) Your secondary practice location is a(n):
 Hospital Ambulatory Surgery Center Professional Office with Specialty

c. If you practice **other than** as an **employee** OR an **unincorporated solo practitioner**, specify:

- (i) Formal business, corporate or partnership name: _____
- (ii) List the names of all partners or members of your professional association/corporation who provide professional services: _____

d. Provide the following information for all of the states in which you practice:

<u>State</u>	<u>License No.</u>	<u>Effective Date</u>	<u>Expiration Date</u>	<u>Active (Yes/No)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If NONE, please attach an explanation.

e. The practice for which coverage is requested is:

- full-time part-time "moonlighting"

If the practice for which coverage is requested is part-time or "moonlighting" answer the following:

- (i) Provide the name and address of your full-time position and number of weekly hours not including on-call.

- (ii) Attach a Certificate of Insurance evidencing that you have Professional Liability Insurance for your full-time practice.

f. Do you work for and/or accept work assignments or placements from any locum tenens company?..... Yes No

If Yes, complete the following for each company.

<u>Name of Company</u>	<u>Address</u>	<u>Employee or Independent Contractor</u>	<u>No. of Hrs. Each Month</u>	<u>Is Prof. Liab. Insurance Provided to You? (Yes/No)*</u>
_____	_____	_____	_____	_____

* If Yes, attach a copy of your Certificate of Insurance.

If No, are you requesting coverage for this activity?..... Yes No

g. Do you own a locum tenens company?..... Yes No

If yes, are you requesting coverage for this company? Yes No

h. Are you a free-lance locum tenens not placed by or associated with any locum tenens company?..... Yes No

i. Are you currently in active military service?..... Yes No

j. Are you licensed in accordance with applicable state and federal regulations?..... Yes No
If no, please attach an explanation.

k. Please indicate the approximate division of your patients or clients among:
Bariatric Surgery _____% Ophthalmologic _____%
Obstetrical _____% Plastic or other Cosmetic Surgery _____%
Dental/Oral Surgery _____% Podiatric _____%
Pediatric _____% Pain Management _____%
Surgical (describe) _____%

Must total 100%

l. Are you supervised by an Anesthesiologist at each location for which coverage is requested?..... Yes No
If Yes, is 100% of your practice supervised by an Anesthesiologist? Yes No

If No, what percentage of your practice is supervised by the following:

_____ % Another CRNA	_____ % Dentist/Oral Surgeon	_____ % Other Physician
_____ % Anesthesiologist	_____ % Ophthalmologist	_____ % Plastic/Cosmetic Surgeon
_____ % Bariatric Surgeon	_____ % Podiatrist	

m. During administration of all anesthetics, do you use a pulse oximeter monitor?..... Yes No
If No, explain. _____

n. During all anesthetics,
(i) Is an electrocardiogram continuously displayed? Yes No
If No, explain. _____
(ii) How often is arterial blood pressure determined and evaluated? _____
(iii) How often is heart rate determined and evaluated? _____
(iv) How is circulatory function evaluated? _____

o. During all general anesthesia, do you use an end tidal CO2 monitor? _____ Yes No
If No, explain _____

p. During all general anesthesia using an anesthesia machine, do you:
(i) Use an oxygen analyzer with a low concentration limit alarm? Yes No
If No, explain. _____
(ii) Test proper functioning of alarms prior to each use? Yes No
If No, explain. _____

q. When ventilation is controlled by a mechanical ventilator, do you:
(i) Use a device equipped with a full set of safety alarms? Yes No
If No, explain. _____
(ii) Test proper functioning of alarms prior to each use? Yes No
If No, explain. _____

r. Are you present in the operating room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care? Yes No
If No, explain. _____

- s. Provide the following:
- | | Weekly | Annually |
|---|--------|----------|
| (i) Average number of patients you saw during the last 12 months for all jobs. | _____ | _____ |
| (ii) Estimated number of patients you will see during the next 12 months for all jobs. | _____ | _____ |
| (iii) Estimated number of patients you will see during the next 12 months for all jobs for which coverage is requested. | _____ | _____ |
- t. Provide the following (exclude on-call hours):
- (i) Average number of weekly practice hours for all jobs: _____
- (ii) Average number of weekly practice hours for all jobs for which coverage is requested: _____
- u. Do you anticipate any changes in your practice in the next year?..... Yes No
If Yes, attach a detailed explanation.

3. EDUCATION AND TRAINING:

a. Provide the following information:

	<u>Name of Institution</u>	<u>City</u>	<u>State</u>	<u>Date Completed</u>
Nursing School	_____	_____	_____	_____
Graduate School	_____	_____	_____	_____

- b. Provide a detailed summary of where you have practiced your profession since completing your training: _____
- c. Are you a member of any professional societies?..... Yes No
If Yes, provide information regarding your membership(s): _____
- d. Please describe Professional training including formal classroom education, tutorials, seminars, etc., on attached sheet, or attach a current curriculum vitae (C.V.).
- e. Have you ever failed any professional licensing or specialty organization examination? Yes No
If yes, please attach a detailed explanation, including dates and location.

4. INSURANCE HISTORY:

List your prior Professional Liability Insurance for each of the last five (5) years, including the current year:

Limits of Liability			Claims Made or		
Insurance Company	Premium	Eff./Exp. Dates	Occurrence Form	Retroactive Date	
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

5. APPLICANT HISTORY: (ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS)

- a. Have you:
- (i) Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association?..... Yes No
- (ii) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No
- (iii) Ever been treated for alcoholism or drug addiction? Yes No

