

PMIS

Alternative Risk Physician Program

Full Name:

Mailing address:

Street:

City:

State:

Zip:

Phone:

Fax:

email:

Social security number:

date of birth:

Medical Specialty:

Subspecialty:

% of practice:

Average weekly patient load:

% locum tenens:

Check appropriate category:

no surgery except incision of boils, cysts , other superficial abscesses or minor suturing

assisting in surgery on your own patients ____ # annually

assisting in surgery on patients of others ____ # annually

normal OB (deliveries) ____ # annually

major surgery (under general, spinal or caudal anesthesia) ____ # annually

minor surgery ____ # annually describe: _____

Indicate which of the following you perform:

abortions ____ # annually

acupuncture or acupresure

anesthesia

angiography

appendectomies

cesarean sections

chemobrasion colonoscopy

cosmetic surgery (plastic, elective)

cosmetic surgery (plastic, traumatic)

cryosurgery

dermabrasion

endoscopic procedures

gastric by-pass surgery

general anesthesia

hair growing or transplants

- banding hemorrhoids
- hemorrhoidectomy
- hernias
- hysterectomies
- injection of implants in breasts
- Insertions of IUD's
- laparoscopy
- lasers therapy or surgery
- lumbar puncture
- needle biopsy
- OB (deliveries) at other than a licensed acute care hospital
- office x-rays
- open reduction of fractures
- radial keratotomy
- radiation therapy
- Shock therapy
- silicone implants
- spinal anesthesia
- suction assisted lipectomy
- T & A
- thoracic surgery
- tubal ligations
- vascular surgery
- vasectomies
- weight control (other than diet)
- any procedure not usual or customary
- any procedure not approved by the AMA or FDA
- experimental procedures

If you answered yes to any of the above, please explain:

Please write in your answers below:

Has membership in any professional association or society ever been revoked or refused? _____

Has a hospital suspended, restricted or refused your staff privileges, or have you voluntarily surrendered, limited or withdrawn your privileges anytime while under peer investigation? _____

Have you ever voluntarily surrendered, non-renewed or had a state license to practice medicine refused or suspended or revoked, or had any disciplinary or advisory action taken? _____

Have you ever voluntarily surrendered or had a narcotics license refused, suspended, revoked or restricted? _____

Have you ever been, or are you currently being treated for alcoholism, narcotic addiction, or mental illness including inpatient, outpatient or counseling? _____

Have you ever been convicted of a felony? _____

Have you ever suffered from or been treated for any chronic illness or physical defect or had counseling or had mental health therapy or taken psychiatric medications for more than 30 days? _____ Are you currently? _____

Have you ever had professional liability insurance refused, canceled, non-renewed, surcharged or restricted? _____

Have you ever sued any facility or physician for libel, slander, restraint of trade or denial or civil rights? _____

Do you work in an industrial clinic? _____

Have you ever had a grievance filed against you with your county of state medical society or have been censured or received a private reprimand from any organization? _____

Have there been any significant changes to your practice in the last year? _____ Have you changed specialty, added or deleted procedures? _____

If yes to any of the above, please explain fully:

Has any claims or suit for alleged malpractice been brought against you? _____

If so, give full explanations and attach additional sheets as necessary.

Current coverage/policy limits:

Claims made: _____

occurrence: _____

Effective date:

retroactive date:

Deductible:

Please attach current CV and please attach a copy of your most current, or in-force, medical professional liability insurance policy declarations page (the face sheet of your policy showing your name, limits, retrodate, premium, addresses, ISO code or other pertinent information)

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