



CERTIFIED REGISTERED NURSE ANESTHETIST APPLICATION

APPLICATION CHECKLIST

- Type or print clearly in ink.
- Answer all questions fully and completely. Partially completed applications cannot be processed and will be returned to you for completion.
- The application asks that you provide information regarding hospital affiliations, practice associations, etc. This information is requested to provide us with an understanding of your practice but does not mean that a policy, if issued, would cover such entities or persons.
- If you wish to explain any of your answers, please use the Remarks section on page 9. If you need more space, please attach additional pages.
- Please ensure that you sign and date the application on page 10 for California and Rhode Island applicants or page 11 for Alaska applicants.
- Please provide loss runs for the previous ten years, or since the date you began practicing medicine, whichever is more recent. The loss runs must be less than 90 days old.
- Please make a copy of the completed application and supporting documents for your records.
- If you engage in the electronic management and distribution of patients' protected health information (PHI), and such information is released to NORCAL, you are considered a *Covered Entity* under HIPAA and thus required to maintain a Business Associate Agreement with NORCAL. For your convenience, NORCAL has enclosed a Business Associate Agreement to satisfy the HIPAA requirement. You do not need to sign and/or return the Agreement; it is intended simply to be filed along with your other HIPAA compliance documents. The Agreement can also be found online at www.norcalmutual.com.

SECTION I IDENTIFYING INFORMATION

Applicant Name (Last, First Middle)		Professional Designation		<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) / /	
Primary Practice Address	City	County	State	Zip Code	Telephone # () -	Fax # () -
Home Address	City		State	Zip Code	Telephone # () -	Fax # () -
E-mail Address						

SECTION II COVERAGE INFORMATION

1. Please identify the name of the physician or group under whose professional liability insurance coverage you wish to apply:

(Name of Physician/Group)

NOTE: If your application is approved, you will be added to the physician's or group's policy via endorsement and will share in the physician's or group's limits of liability. Coverage will be extended only while you are acting within the course and scope of your duties for the physician or group and will be subject to the terms, conditions and limitations of the policy.

2. Please describe your association with the physician or group identified above (e.g., employee):

3. Please identify the Requested Effective Date (the date you wish coverage to begin)

_____ 12:01 a.m. Local Time
Month Day Year

NOTE: NORCAL should receive the application at least thirty days before the Requested Effective Date.

SECTION III PRACTICE LOCATIONS

1. Please complete the following regarding all non-hospital locations at which you will render professional health care services as of the Requested Effective Date. Please photocopy this page if additional space is needed.

Name of Location	Address	Location Type (i.e., office, surgery center, nursing home, etc.)

2. Please complete the following regarding any other non-hospital locations at which you have rendered professional health care services within the past ten years. Please photocopy this page if additional space is needed.

Name of Location	Address	Location Type (i.e., office, surgery center, nursing home, etc.)	Dates From (Mo/Yr) To (Mo/Yr)
			-
			-
			-

3. As of the Requested Effective Date, will you provide any professional health care services outside the scope of your duties for the physician or group identified in Section II? Yes No

If **yes**, please complete the following. Please photocopy this page if additional space is needed.

Name of Location	Address	Description of Practice and Hours Per Week	Name of Insurer

4. Please list all hospitals at which you currently maintain or will be applying for staff privileges. Please photocopy this page if additional space is needed.

Name of Facility	Location (City and State)	Type of Privileges
		<input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Provisional <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Provisional <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Active <input type="checkbox"/> Courtesy <input type="checkbox"/> Pending <input type="checkbox"/> Provisional <input type="checkbox"/> Other: _____

5. If you checked "provisional" or "other," please explain in the Remarks section on page 9.
6. If you do not have hospital privileges, please explain why you do not have them and identify the means you use to admit your patients should the need arise:

SECTION IV GENERAL PRACTICE INFORMATION

1. Please provide the following based on your work on behalf of the physician or group identified in Section II:

Average number of hours that you will work per week: _____

Average number of patients that you will care for per week: _____

SECTION V LICENSES

1. Please complete the following regarding *all* states where you are or have been licensed as a health care professional:

State	License Type (e.g., RN or CRNA)	License Number	Current Status	If Inactive, Reason for Inactive Status
			<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	
			<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	
			<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	
			<input type="checkbox"/> Active – Permanent <input type="checkbox"/> Active – Temporary <input type="checkbox"/> Inactive	

2. Federal DEA License: Number: _____ Status: _____ Expiration Date: _____

SECTION VI EDUCATION, TRAINING AND CERTIFICATION

1. List all training programs you have entered, whether or not you graduated or completed the training.

Registered Nursing Program:

 Name of School City, State Dates (from – to)

Nurse Anesthesia Program:

 Name of School City, State Dates (from – to)

Other Training:

Type

 Name of Location City, State Dates (from – to)

2. Did you successfully complete each training program that you started? **Yes** **No**

If **no**, please explain in the Remarks section on page 9.

3. Please explain any gaps in your training, if applicable, in the Remarks section on page 9.

4. Please provide proof of your certification by the American Association of Nurse Anesthetists Council on Certification (or Recertification) of Nurse Anesthetists.

SECTION VII ANESTHESIA AND PROCEDURES

Anesthesia

1. Do you have hospital privileges for all of the types of anesthesia that you provide? **Yes** **No**

If **no**, please explain:

2. When applicable, do you always follow the current American Society of Anesthesiologists' "Standards for Basic Anesthetic Monitoring," "Guidelines for Regional Anesthesia in Obstetrics" and "Guidelines for Non-Operating Room Anesthetizing Locations?" **Yes** **No**

If **no**, please explain:

3. When applicable, do you always follow the current American Association of Nurse Anesthetists' "Scope and Standards for Nurse Anesthesia Practice," "Standards for Office-Based Anesthesia Practice" and "Guidelines for the Management of the Obstetrical Patient?" **Yes** **No**

If **no**, please explain:

4. Do you cover labor and delivery? **Yes** **No**

If **yes**, and the patient has been administered regional analgesia for labor, do you (or does a physician trained in anesthesia or another CRNA) remain in the hospital until the patient has delivered and the patient's condition has stabilized? **Yes** **No**

If **no**, please identify your (or a physician trained in anesthesia or another CRNA's) maximum response time to the hospital:

5. Do you provide professional health care services (not limited to obstetrical care) during delivery (including the immediate labor, puerperium and/or neonatal period) in any facility or any place other than a licensed acute care hospital? **Yes** **No**

If **yes**, please explain:

6. Do you administer anesthesia for patients who undergo spinal manipulation under anesthesia? **Yes** **No**

If **yes**, please identify the name(s) and designation(s) of the practitioner(s) who perform the manipulations, identify the locations where the manipulations are performed and provide proof of professional liability insurance for the practitioner(s):

7. Do you administer spinal/epidural anesthesia, moderate (conscious) sedation, deep sedation or general anesthesia to patients undergoing procedures in any non-hospital facility? Yes No

If yes:

- a. Please ensure that all such locations were identified in Section III of the application.
- b. Please provide proof that this location is accredited by the AAAASF, AAAHC or similar type of organization, or proof that it is certified by Medicare as an ambulatory surgery center.
- c. Is it limited to ASA class I and class II patients? Yes No

If no, please identify the class(es) of patients, and for each class, identify the types of procedures performed and types of anesthesia used on the patients (attach additional pages as necessary):

Class III Class IV Class V

Chronic Pain Management

1. Do you perform chronic pain management procedures? Yes No

If yes, please complete the following. Please photocopy the page if you need additional space:

Procedure	Number Performed Per Year	Location(s) Where Performed
		<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility with Crash Cart <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility with Crash Cart <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility with Crash Cart <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility with Crash Cart <input type="checkbox"/> Other: _____
		<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility with Crash Cart <input type="checkbox"/> Other: _____

* Please provide proof that this location is accredited by the AAAASF, AAAHC or similar type of organization, or proof that it is certified by Medicare as an ambulatory surgery center.

2. Do you have hospital privileges for all chronic pain management procedures that you perform? Yes No

If no, please explain and identify the procedure(s) for which you do not have hospital privileges:

3. If you indicated that you perform any chronic pain management procedure(s) in a nonaccredited facility with a crash cart, is the crash cart equipped with at least cardiac drugs, basic airway and IV access equipment, a cardiac monitor/defibrillator *and* supplemental oxygen? **Yes** **No**

If no, please explain:

Drugs, Devices and Clinical Studies

1. Do you use, administer, distribute or prescribe any drugs, pharmaceuticals, devices or equipment disapproved or not yet approved by the United States Food and Drug Administration (FDA) for treatment of human beings? **Yes** **No**

If yes:

a. Please describe: _____

b. If the applicable use(s) is/are part of a clinical study, please provide the following information for each clinical study:

- i. A copy of the clinical study's protocol
- ii. Proof of its FDA or IRB approval, if not stamped on the protocol
- iii. A copy of the consent form, if it is not FDA or IRB approved

2. Do you use, administer, distribute or prescribe any FDA-approved drugs, pharmaceuticals, devices or equipment in a manner not approved by the FDA (i.e., off-label use)? **Yes** **No**

If yes, are all of your off-label uses supported by appropriate precedent for effectiveness and safety (i.e., within the standard of care)? **Yes** **No**

If no:

a. Identify each drug, pharmaceutical, device and/or equipment, its FDA-approved use and your off-label use:

b. Provide a copy of the informed consent form that you use for each such off-label use.

SECTION VIII SUPPLEMENTAL QUESTIONS

If you answer YES to any one of the following questions, you must provide a detailed written narrative (including, but not limited to, date of occurrence, reason for occurrence and resolution) and pertinent documentation (e.g., nonrenewal or declination notice, medical board documents, letters from hospital, diversion program, treating physician, etc.).

1. Has any professional liability insurance company **ever** canceled, nonrenewed or modified (e.g., involuntarily reduced limits, restricted coverage, added a deductible and/or surcharge, etc.) your insurance, declined to offer you coverage or notified you of its intent to pursue such action? Yes No
2. Has your license to practice as a health care professional in any jurisdiction, your DEA registration, or any applicable controlled substance license or registration in any jurisdiction **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, fined, subject to probationary terms or conditions or otherwise investigated or limited in any way? Yes No
3. Has any governmental agency **ever** investigated you, placed you on probation, suspended you or taken any action against you? Yes No
4. Have your clinical privileges, memberships, contractual participation in or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, subject to probationary terms or conditions or otherwise investigated or limited in any way for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? Yes No
5. Have you **ever** surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges with; terminated contractual participation or employment in; or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence, improper professional conduct or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? Yes No
6. Have you **ever** been convicted of or admitted to committing a misdemeanor, including a DUI, but excluding minor traffic violations? Yes No
7. Have you **ever** been charged with, been convicted of or admitted to committing a felony? Yes No
8. Have you **ever** been accused of sexual misconduct? Yes No
9. Have you **ever** had any contact of a sexual nature with a patient or former patient? Yes No
10. Have you **ever** had a problem with, been evaluated for, been diagnosed with, been treated for or are currently being treated for alcohol, narcotic or any other substance addiction, sexual addiction or mental illness? Yes No
11. Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice? Yes No

FOR CALIFORNIA AND RHODE ISLAND APPLICANTS ONLY

Warranties and Authorization to Release Information

I understand that this application and any supplemental information supplied by me or on my behalf is incorporated into and made a part of any policy of insurance that may be issued to the physician or group by NORCAL ("the Company").

I understand it is my responsibility to obtain and review a copy of the insurance policy. I also understand I may ask any questions about any policy language that is not clear to me.

I represent and warrant the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the Company in considering this application for insurance.

I understand that if a dispute arises between me and NORCAL, the dispute will be submitted to binding arbitration.

I understand that the physician's or group's policy (including my coverage), if issued, can be canceled for failure to pay the premium by the due date stated on the invoice.

I understand that, in the event my coverage is canceled, any unearned premiums will be refunded to the person or group that paid NORCAL (i.e., the payer).

I understand that I (or the physician's or group's Authorized Representative) must notify NORCAL immediately, in writing, if there are any changes from what I have previously described in any information supplied by me or on my behalf, including changes in my partners or associates, medical license, professional office premises, medical procedures or administrative responsibilities, or hospital privileges.

I understand that NORCAL generally does not cover any liability of another person or organization that I assume under an oral or written contract or agreement.

I understand that NORCAL generally does not cover any liability arising from any goods or products developed, manufactured, assembled, sold, handled, distributed or disposed of by me or others trading under my name.

I understand that if my application is approved and I am added to the physician's or group's policy, coverage would be extended only while I am acting within the course and scope of my duties for the physician or group, subject to the terms, conditions and limitations of the policy.

I authorize the release and exchange of information between NORCAL Mutual Insurance Company and its authorized representatives and my past and present medical group(s), association(s), society(ies) and their insurance agents, brokers or consultants; any hospital or other health care facility or organization where I presently hold, am applying for or previously held staff privileges or panel membership; prior and current insurance carriers; government agencies; educational institutions and any other entities or individuals NORCAL deems necessary. I understand NORCAL, at its discretion, may obtain background information to aid in its evaluation of my insurability. I agree that the individual or organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I further agree to hold harmless and release NORCAL, its agents and representatives, from any liability arising from any exchange of information about me.

Signature

Date

Name (Print)

FOR ALASKA APPLICANTS ONLY

Representations and Authorization to Release Information

I understand that this application and any supplemental information supplied by me or on my behalf is incorporated into and made a part of any policy of insurance that may be issued to the physician or group by NORCAL (“the Company”).

I understand it is my responsibility to obtain and review a copy of the insurance policy. I also understand I may ask any questions about any policy language that is not clear to me.

I represent the truth of my statements and information mentioned herein, and that I have not intentionally withheld any information that could influence the judgment of the Company in considering this application for insurance.

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I understand that NORCAL generally does not cover any liability of another person or organization that I assume under an oral or written contract or agreement.

I understand that NORCAL generally does not cover any liability arising from any goods or products developed, manufactured, assembled, sold, handled, distributed or disposed of by me or others trading under my name.

I understand that if my application is approved and I am added to the physician’s or group’s policy, coverage would be extended only while I am acting within the course and scope of my duties for the physician or group, subject to the terms, conditions and limitations of the policy.

I authorize the release and exchange of information between NORCAL Mutual Insurance Company and its authorized representatives and my past and present medical group(s), association(s), society(ies) and their insurance agents, brokers or consultants; any hospital or other health care facility or organization where I presently hold, am applying for or previously held staff privileges or panel membership; prior and current insurance carriers; government agencies; educational institutions and any other entities or individuals NORCAL deems necessary. I understand NORCAL, at its discretion, may obtain background information to aid in its evaluation of my insurability. I agree that the individual or organization releasing the information, its agents, servants and employees shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I further agree to hold harmless and release NORCAL, its agents and representatives, from any liability arising from any exchange of information about me.

Signature

Date

Name (Print)

CLAIM INFORMATION FORM

Name of Patient: _____ Gender: Male Female

Age of Patient (at time of treatment): _____

Name of Claimant (if different than patient): _____

Your Relationship to Patient (e.g., health care provider, consultant):

Allegation: _____

Location of Incident: _____

Additional Defendants: _____

Date Incident or Claim Was Reported to the Insurance Company: _____

Name of Insurance Company: _____

Disposition or Current Status of the Incident, Claim or Suit:

Open

- Incident has been reported but claim or suit has not been filed
- Claim or suit has been filed and is awaiting start of arbitration, mediation, trial, etc.
- Claim or suit is currently in arbitration or mediation or is being tried in court
- Settlement has been made or judgment returned but remains open

Closed Date Closed (month/day/year): _____

- Incident was reported but claim or suit was not filed
- Claim or suit was filed but was dismissed or dropped before trial
- Claim or suit was filed but settlement was made
- Verdict or judgment was made in your favor
- Verdict or judgment was made in favor of the plaintiff

Total loss payment amount (if payment made): _____

Amount paid on your behalf (if different): _____

Total verdict amount (if different than total loss payment amount): _____

