

APPLICATION FOR (Check Appropriate Box)

LOCUM TENENS

Locum tenens coverage is available for a provider who is temporarily substituting for a NORCAL insured physician and has compatible training/experience.

ENDORSED PHYSICIAN

Endorsed Physicians coverage is available for a physician who is providing services on behalf of a NORCAL insured on a part-time basis and is **NOT** substituting for a NORCAL insured physician.

NOTES: Locum Tenens and Endorsed Physicians would be insured only while acting within the course and scope of their duties for the Named Insured identified. A Locum Tenens will share in the limits of liability and coverage of the provider for whom he or she is temporarily substituting.

Endorsed Physicians will share in the limits of liability and coverage of the Named Insured.

COVERAGE AUTHORIZATION INFORMATION

THIS SECTION MUST BE COMPLETED BY THE NAMED INSURED.

Policy Number: Named Insured:

- I authorize the applicant identified in this application to serve as Locum Tenens under this policy.
- I authorize the applicant identified in this application to serve as an Endorsed Physician under this policy on a part-time basis. He/she is **NOT** substituting for any other physician insured under this policy.

Rating Information

Please identify the date the applicant will begin providing service on your behalf: 12:01 a.m. Local Time
(mm/dd/yyyy)

Estimated number of days the applicant will practice on your behalf this calendar year:

Estimated number of hours per week the applicant will practice on your behalf:

Signature (Named Insured or Authorized Representative)

Date

(mm/dd/yyyy)

Name (Print)

SECTION I**IDENTIFYING INFORMATION**

Applicant Name

*(Last)**(First)**(Middle)* MD DO Male Female

Date of Birth

(mm/dd/yyyy)

Practice Address

*(City)**(State)**(Zip Code)*Telephone # *(Including Area Code)*Fax # *(Including Area Code)*

Applicant E-Mail Address

SECTION II**LICENSES**

1. Please complete the following regarding *all* states where you are presently or have been previously licensed to practice medicine in any capacity:

State

License Number

State

License Number

SECTION III**HOSPITAL PRIVILEGES**

1. Please list all hospitals at which you currently maintain staff privileges:

Name of Facility

Location (City/State)

Type of Privileges?

 Active Provisional Courtesy Pending Other: Active Provisional Courtesy Pending Other: Active Provisional Courtesy Pending Other:

2. If you do not have hospital privileges, please identify which means you use to admit your patients should the need arise:

 Another Physician Hospitalist 911 None (reason): Other (specify):**SECTION IV****EDUCATION AND TRAINING**

1. List all schools and postgraduate training programs you have entered, whether or not you graduated or completed your training. You may submit your curriculum vitae (CV) in lieu of providing the information in the table below, as long as the CV is current and provides all of the information requested in the table and you complete Questions 2 and 3.

SECTION IV (cont)

EDUCATION AND TRAINING

Medical/Osteopathic School	Degree	School	City, State	Dates (mm/yyyy)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	From: <input type="text"/>
			Country	To: <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	From: <input type="text"/>
			Country	To: <input type="text"/>
Residency	Type	Facility	City, State	Dates (mm/yyyy)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	From: <input type="text"/>
			Country	To: <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	From: <input type="text"/>
			Country	To: <input type="text"/>
Residency	Type	Facility	City, State	Dates (mm/yyyy)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	From: <input type="text"/>
			Country	To: <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	From: <input type="text"/>
			Country	To: <input type="text"/>
Fellowship	Type	Facility	City, State	Dates (mm/yyyy)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	From: <input type="text"/>
			Country	To: <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	From: <input type="text"/>
			Country	To: <input type="text"/>
Other Training (specify)	Type	Facility	City, State	Dates (mm/yyyy)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	From: <input type="text"/>
			Country	To: <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	From: <input type="text"/>
			Country	To: <input type="text"/>

2. Did you successfully complete each training program identified above (or on your attached CV)? Yes No

If no, please explain in the Remarks Section.

3. Please identify each medical specialty/field of medicine in which you practice and the percentage of your practice that is devoted to that medical specialty/field of medicine. **NOTE:** The percentage total must equal 100%.

Primary specialty/field of medicine: %

Additional specialty/field of medicine: %

4. Have you ever been denied certification by a specialty board, or has your eligibility, certification or recertification status changed other than from eligible to certified? Yes No

If yes, please explain in the Remarks Section.

SECTION V

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., medical board documents, letters from hospital, diversion program, treating physician, etc.).

1. Has your license to practice medicine 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

2. Has any governmental agency **ever** investigated you, placed you on probation, suspended you or taken any action against you? Yes No

3. 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
4. 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
5. Have you **ever** been convicted of or admitted to committing a misdemeanor, including a DUI, but excluding minor traffic violations? Yes No
6. Have you **ever** been charged with, been convicted of or admitted to committing a felony? Yes No
7. Have you **ever** been accused of sexual misconduct? Yes No
8. Have you **ever** had any contact of a sexual nature with a patient or former patient? Yes No
9. Do you know if any individual who works on your behalf has a prior history or propensity for sexual misconduct? 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 your medical specialty? Yes No
12. 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

SECTION VI

CLAIMS HISTORY

1. Within the past seven (7) years has a malpractice claim or suit been brought against you, or have you been notified of your involvement in a malpractice claim or suit, either directly or indirectly? Yes No
2. To your knowledge, within the past seven (7) years has a malpractice claim been brought against any organization (e.g., medical group, hospital, etc.) as a result of your rendering or failing to render professional health care services? Yes No
3. Are you aware of any medical incident or accident, conduct, circumstance or occurrence that might reasonably be expected to give rise to a claim or suit against you, directly or indirectly, even if you believe the claim or suit would be without merit? Yes No

If you answered yes to questions 1, 2 or 3, please complete a Claim Information Form for each applicable claim, suit, incident, conduct, etc. If you are completing the Claim Information Form electronically and need to report more than one claim, suit, incident, conduct, etc., you can download additional Claim Information Forms at www.norcalmutual.com/resources/applications.php.

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., attending physician, primary surgeon, assistant surgeon, consultant, etc.):

Allegation:

Location of Incident:

Additional Defendants:

Date (mm/dd/yyyy) Incident or Claim Was Reported to the Insurance Company:

Name of Insurance Company:

Disposition or Current Status of the Incident, Claim or Suit: Open Closed (Date)
(mm/dd/yyyy)

Total verdict or settlement amount:

Amount paid on your behalf (if different):

CLAIM INFORMATION NARRATIVE

Please describe your care and treatment of the patient. Attach additional pages as needed. Your narrative must provide adequate clinical detail to allow proper evaluation by a committee of physicians and must include the following information:

- Condition and diagnosis at time of treatment
- Dates and a description of treatment rendered
- Condition of patient subsequent to treatment
- Copies of patient(s) chart(s) and operative report(s) as appropriate

I understand the information submitted herein becomes part of my insurance application as submitted.

Signature (If you have completed the application digitally, please print and sign it)

Date

(mm/dd/yyyy)

Name (Print)

REPRESENTATIONS, WARRANTIES, AND AUTHORIZATION TO RELEASE INFORMATION

NOTE: "Warrant" in the following statement is not applicable to Alaska, Arizona or New Mexico health care providers.
By statute, Alaska, Arizona or New Mexico health care providers are only required to represent the truth of their statements and information.

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my coverage. I agree to notify NORCAL Mutual Insurance Company immediately if my practice changes in any way and of any change in the information contained in this questionnaire.

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 *(If you have completed the application digitally, please print and sign it)*

Date

(mm/dd/yyyy)

Name *(Print)*