



HEALTH CARE EXTENDER APPLICATION For Physician Assistants and Nurse Practitioners

If you engage in the electronic management and distribution of patients' protected health information (PHI), and such information is released to NORCAL Mutual, you are considered a *Covered Entity* under HIPAA and thus required to maintain a Business Associate Agreement with NORCAL Mutual. For your convenience, NORCAL Mutual 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"/> PA License # _____ <input type="checkbox"/> NP License # _____	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)
E-mail Address:			

SECTION II COVERAGE INFORMATION

NOTE: Section II must be completed by the Named Insured. If the application is approved, the applicant will be added to the Named Insured's policy via endorsement. Coverage will be extended only while the applicant is acting within the course and scope of their duties for the Named Insured and will be subject to the terms, conditions and limitations of the policy.

1. Please identify the name of the physician or group the applicant is joining:

Name of Physician/Group

Policy Number

2. Requested Effective Date of Coverage: _____ 12:01 a.m. Local Time
(mm/dd/yyyy)

3. Please identify the association the applicant maintains with the physician or group identified above:

Employee Independent Contractor Other (please specify) _____

4. Average weekly practice hours for which NORCAL Mutual insurance is desired: _____

5. Please select the type of coverage that is desired.

Shared limits of liability. If approved for coverage, the applicant will share in the Named Insured's limits of liability.

Separate limits of liability.* If approved for coverage, a separate limit of liability will apply.

Locum Tenens. If approved, the applicant will be covered on a shared limits basis while temporarily substituting for an endorsed healthcare extender on your policy.

***NOTE:** If you choose separate limits of liability, and your coverage is subsequently canceled or non-renewed, you will be required to purchase an extended reporting period endorsement (also known as "tail coverage") in order to have coverage for claims and other insured events first reported to NORCAL Mutual on or after the termination date.

6. ***I authorize the applicant to be endorsed under the above policy.***

Print Name

Signature of Physician/Authorized Representative

Date (mm/dd/yyyy)

SECTION III PRACTICE LOCATIONS – To be completed by applicant

1. CURRENT PRACTICE LOCATIONS

Please complete the following regarding all non-hospital locations at which you will render professional health care services as of the Requested Effective Date on behalf of the Named Insured.

Locations where you will practice on behalf of the Named Insured	Location Name	Address	Location Type (i.e., office, surgery center, nursing home, etc.)
Primary Office Location			
Secondary Location			
Additional Location			

2. OUTSIDE WORK

As of the Requested Effective Date, will you provide any professional health care services **NOT** on behalf of and outside of the scope of your duties for the physician or group identified in Section II? Yes No

If yes, please complete the following.

Locations where you will practice <u>outside</u> the scope of your duties for the Named Insured	Address	Description of Practice and Hours Per Week	Name of Insurer

3. PRACTICE HISTORY

Please complete the following regarding any other non-hospital locations at which you have rendered professional health care services within the past seven years.

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

SECTION IV EDUCATION AND TRAINING

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

Training Program:

		-
Name of School	City, State	Dates (from – to) (mm/dd/yyyy)

For Nurse Practitioners Only - Type of Program (check one):

- General
 Acute Care
 Adult
 Adult Psychiatric and Mental Health
 Family
 Family Psychiatric and Mental Health
 Pediatric
 Women's Health
 Other (specify): _____

Postgraduate Training:

Type		-
Name of School	City, State	Dates (from – to) (mm/dd/yyyy)

Other Training:

Type		-
Name of Location	City, State	Dates (from – to) (mm/dd/yyyy)

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

If no, please explain: _____

3. Please explain any gaps in your training, if applicable: _____

SECTION V PROCEDURES AND SERVICES

1. Do you perform any procedures or provide any services that have not been delegated to you by a supervising/collaborating physician(s)? **Yes** **No**

If you answered yes, please identify the procedures or services and explain:

2. Do you perform any procedure in which the patient has been administered an anesthesia other than a topical or local anesthetic? **Yes** **No**

If yes, please explain _____

3. Do you order, prescribe or dispense any controlled substance? **Yes** **No**

If yes, please identify the level(s): Schedule I Schedule II Schedule III Schedule IV Schedule V

If you order, prescribe or dispense controlled substances, please complete the following federal DEA license information:

Number: _____ Status: _____ Expiration Date (mm/dd/yyyy): _____

4. Do you perform cosmetic procedures (e.g., botox, fillers, laser hair removal, laser skin resurfacing, vein treatment, chemical peels, dermabrasion, dermaplaning, etc?) **Yes*** **No**

If **yes**, please list procedures performed: _____

**Provide copy of your training certificate & informed consent form for each procedure.*

Obstetrics

Obstetrics is defined as the care and treatment of pregnancy including, but not limited to, prenatal care, labor, delivery, cesarean section and/or postnatal care.

5. Do you practice obstetrics? **Yes** **No**

If **yes**, please check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> First Trimester Prenatal Care | <input type="checkbox"/> Deliveries (estimated number per year): _____ |
| <input type="checkbox"/> Second Trimester Prenatal Care | <input type="checkbox"/> Cesarean Section |
| <input type="checkbox"/> Third Trimester Prenatal Care | <input type="checkbox"/> Other (specify): _____ |

6. Do you take obstetrical call? **Yes** **No**

If **yes**, please explain:

7. 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:

8. Do you perform or interpret ultrasounds? **Yes** **No**

If **yes**, please explain:

Telemedicine, E-mail and Advertising

Telemedicine is defined as “the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video or data communications. Neither a telephone conversation nor an electronic mail message between a licensed health care practitioner and another licensed health care practitioner and/or between a licensed health care practitioner and a patient constitute telemedicine.”

9. Do you provide telemedicine services? **Yes** **No**

If **yes**, please explain in the Remarks section on page 8.

10. Do you communicate online/via e-mail with patients and/or potential patients?

If **yes**, complete 10a - c.

- a. Please check all that apply to your practice:

- Provide a diagnosis to, treatment for, prescription for or transfer of medical data to any person(s) via the Internet or other electronic mail system, videoconference, telephone or other information systems for whom you have performed a good faith prior in-office examination?

Provide a diagnosis to, treatment for, prescription for or transfer of medical data to any person(s) via the Internet or other electronic mail system, videoconference, telephone, or other information systems for whom you did **not** perform a good faith prior in-office examination?

b. If you communicate online/via e-mail with patients and/or potential patients with whom you did not perform a good faith prior in-office examination, please explain in the Remarks section on page 7.

c. Do any of the patients with whom you communicate online/via e-mail reside in a state other than the one in which your primary office is located? **Yes** **No**

If yes, please explain and identify each state in the Remarks section on page 7.

11. Is there a website related to your practice? **Yes** **No**

If yes, website address(es): _____

SECTION VI SUPERVISION/COLLABORATION – To be completed by primary supervising physician

Supervision/Collaboration

1. Name of primary supervising/collaborating physician:

2. Are you always on-site when the applicant is providing professional healthcare services to patients? **Yes** **No**

If yes, proceed to question 3.

If no, will you be telephonically or electronically available to the applicant? **Yes** **No**

List the number of hours per week the applicant provides services when you are not on-site:

What is the method of supervision provided when you are not on-site:

3. Please identify the method(s) that will be used by you in supervising the care that the applicant provides:

I will examine patients seen by the applicant **on the same day** the applicant provided the care.

Percentage of patients: _____ %

I will review, sign and date the medical records of the patients seen by the applicant.

Percentage of patients' medical records: _____ %

Maximum number of days following the encounter within which the review and countersignature will be completed: _____

Other (specify):

Signature

Date (mm/dd/yyyy)

SECTION VII 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

SECTION VIII 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.

IMPORTANT FOR ALL PHYSICIAN ASSISTANTS: A current copy of written protocols (all states) and delegation of services agreement (California only) between yourself and your supervising physician is on file in the practice office at all times and available for review by NORCAL Mutual if necessary.

Yes No

If no, please explain:

IMPORTANT FOR ALL NURSE PRACTITIONERS: A current copy of written protocols between yourself and your supervising physician is on file in the practice office at all times and available for review by NORCAL Mutual if necessary.

Yes No

If no, please explain:

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

Date (mm/dd/yyyy)

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 (mm/dd/yyyy): _____

Name of Insurance Company: _____

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

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

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

Signature

Date (mm/dd/yyyy)

Name (Print)