

**CRITICAL CARE MEDICINE, ENDOCRINOLOGY, GASTROENTEROLOGY,  
HEMATOLOGY/ONCOLOGY, INFECTIOUS DISEASE, INTERNAL MEDICINE,  
NEPHROLOGY, PULMONARY DISEASE AND RHEUMATOLOGY  
SUPPLEMENTAL QUESTIONNAIRE**

Name (please print)

Policy Number (if currently insured with NORCAL)

**Directions:** Please answer all questions fully and completely. If a question does not apply to your practice, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. **Please ensure that you sign and date the questionnaire on page 3.**

**PROCEDURES**

1. Do you perform biopsies?  Yes  No

If yes, please complete the following table regarding the types of biopsies that you perform:

Name of Organ or Tissue	Type	Estimated Number Performed Per Year
	<input type="checkbox"/> Needle <input type="checkbox"/> Incisional <input type="checkbox"/> Excisional	
	<input type="checkbox"/> Needle <input type="checkbox"/> Incisional <input type="checkbox"/> Excisional	
	<input type="checkbox"/> Needle <input type="checkbox"/> Incisional <input type="checkbox"/> Excisional	
	<input type="checkbox"/> Needle <input type="checkbox"/> Incisional <input type="checkbox"/> Excisional	
	<input type="checkbox"/> Needle <input type="checkbox"/> Incisional <input type="checkbox"/> Excisional	
	<input type="checkbox"/> Needle <input type="checkbox"/> Incisional <input type="checkbox"/> Excisional	
	<input type="checkbox"/> Needle <input type="checkbox"/> Incisional <input type="checkbox"/> Excisional	

2. Do you perform endoscopic procedures?  Yes  No

If yes, please complete the following table regarding the endoscopic procedures that you perform:

Procedure	Estimated Number Performed Per Year	Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Anoscopy		<input type="checkbox"/> Endoscopic Ultrasonography	
<input type="checkbox"/> Bronchoscopy		<input type="checkbox"/> Endoscopic Variceal Ligation	
<input type="checkbox"/> Colonoscopy – Conventional		<input type="checkbox"/> Esophagogastroduodenoscopy	
<input type="checkbox"/> Colonoscopy – Virtual		<input type="checkbox"/> Laryngoscopy	
<input type="checkbox"/> Colposcopy		<input type="checkbox"/> Percutaneous Endoscopic Gastrostomy	
<input type="checkbox"/> Endoscopic Lung Volume Reduction		<input type="checkbox"/> Sigmoidoscopy	
<input type="checkbox"/> Endoscopic Retrograde Cholangiopancreatography		<input type="checkbox"/> Other (specify): _____	
<input type="checkbox"/> Endoscopic Sclerotherapy		_____	

3. Do you perform any other procedures?  Yes  No

If yes, please complete the following table regarding the other procedures that you perform:

Procedure	Estimated Number Performed Per Year	Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Angiography – Coronary		<input type="checkbox"/> Lumbar Puncture/Spinal Tap	
<input type="checkbox"/> Angiography – Noncoronary		<input type="checkbox"/> Pacemaker Insertion – Temporary	
<input type="checkbox"/> Arterial Line Placement		<input type="checkbox"/> Pacemaker Insertion – Permanent	
<input type="checkbox"/> Cardioversion – Elective		<input type="checkbox"/> Paracentesis	
<input type="checkbox"/> Catheterization – Diagnostic – Right Heart		<input type="checkbox"/> Pericardiocentesis	
<input type="checkbox"/> Central Line Placement		<input type="checkbox"/> Pneumatic Esophageal Dilation for Strictures	
<input type="checkbox"/> Continuous Renal Replacement Therapy		<input type="checkbox"/> Pulmonary Function Testing & Interpretation	
<input type="checkbox"/> Bronchial Provocative Tests		<input type="checkbox"/> Snare Polypectomy	
<input type="checkbox"/> Dialysis – Hemodialysis		<input type="checkbox"/> Swan Ganz placement & monitoring	
<input type="checkbox"/> Dialysis – Peritoneal		<input type="checkbox"/> Thoracentesis/Pleuracentesis	
<input type="checkbox"/> Electrocardiogram Performance and Interpretation		<input type="checkbox"/> Tumor Ablation	
<input type="checkbox"/> Endotracheal Intubation		<input type="checkbox"/> Venipuncture	
<input type="checkbox"/> Esophageal Dilation		<input type="checkbox"/> Ventilator Management	
<input type="checkbox"/> Esophageal Sclerotherapy		<input type="checkbox"/> Other (specify):	
<input type="checkbox"/> Hemorrhoid Treatment (specify types):		_____	
_____		_____	
<input type="checkbox"/> Holter Monitor Performance and Interpretation		_____	
		_____	

4. Do you have hospital privileges for all procedures that you perform?  Yes  No

If no, please identify the procedure(s) and explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Do you provide sleep medicine services?  Yes  No

If yes, please describe the sleep medicine services that you provide and the location(s) where you provide them:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. Do you provide critical care services other than those that might be required in emergent situations?  Yes  No

If yes, and you have not completed an Accreditation Council for Graduate Medical Education or American Osteopathic Association –approved fellowship in critical care medicine, please do the following:

- Provide proof of your training and hospital privileges for critical care
- Identify the type(s) of critical care services that you provide, the location(s) where you provide the services and the percentage of your practice devoted to critical care medicine:

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7. Do you administer chemotherapy medication?  Yes  No

If yes, and you have not completed an Accreditation Council for Graduate Medical Education or American Osteopathic Association –approved fellowship in oncology, please explain and provide proof of your chemotherapy training, a description of your experience in administering it, your informed consent form and your written protocol:

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## REMARKS

Beneath “Question Number,” please indicate the question number and, if applicable, the letter (for example, 2 or 3b):

Page Number	Section Number	Question Number	Remarks
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Please provide any additional information material to the risk that has not otherwise been addressed in this questionnaire:

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## REPRESENTATIONS AND WARRANTIES

**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.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name