

Medical Genetics

Supplemental Questionnaire



INTRODUCTION

Your Full Name:

Policy Number:

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 2.**

SECTION I

PROCEDURES

1. Do you perform the following?

Therapeutic Procedures (specify): <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Amniocentesis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chorionic Villus Sampling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Percutaneous Umbilical Blood Sampling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Invasive Diagnostic Tests (specify): <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered yes to any one of the above, please provide the following for each procedure:

- The estimated number that you perform each year
- A description of your training, including the date(s), location(s), number of hours, etc.
- Proof of your training and hospital privileges

2. Do you always refer a patient to his or her primary care physician if you discover a medical condition (other than the genetic disorders that you treat) through a physical examination? Yes No

If no, please explain:

SECTION II**REMARKS**

Please provide any additional information to further describe your practice that has not otherwise been addressed in this questionnaire:

REPRESENTATIONS AND WARRANTIES

NOTE: "Warrant" in the following statement is not applicable to Alaska or Arizona health care providers. By statute, Alaska or Arizona 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 on this questionnaire.

Signature

Date

(mm/dd/yyyy)

Name (Print)