

UROLOGY 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 2.**

PROCEDURES

1. Do you hold yourself out as a urogynecologist and/or specialist in reconstructive pelvic surgery? **Yes** **No**
2. Do you perform surgical procedures to treat any of the following?
 - Urinary Incontinence **Yes** **No**
 - Fecal Incontinence **Yes** **No**
 - Pelvic Floor Dysfunction or Prolapse **Yes** **No**
 - Vaginal Fistulas **Yes** **No**
3. If you answered yes to question 1 or if you answered yes to any item in question 2, please provide the following:
 - Proof of your training in urogynecology and/or for the applicable procedures
 - Proof of your hospital privileges in urogynecology and/or for the applicable procedures
 - Description of your experience in urogynecology and/or in performing the applicable procedures
4. Do you perform penile augmentation procedures/surgery? **Yes** **No**

If yes, please identify the procedures and explain:

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:

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