

CARDIOLOGY

SUPPLEMENTAL QUESTIONNAIRE

Your Full Name: _____ Policy Number: _____
 (Please Print)

Directions: Please complete the following questions regarding your practice. 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. **Your signature is required on page 3.**

SECTION I: Procedures

1. Please indicate with an **X** which of the following procedures you perform and provide the estimated number of procedures you perform per year.

Noninvasive Procedures

If you do not perform any of the procedures listed below, please check here.

Procedure	Estimated # Performed Per Year
<input type="checkbox"/> Cardiac MRI	
<input type="checkbox"/> Cardioversion	
<input type="checkbox"/> Catheterization – Right Heart	
<input type="checkbox"/> Computerized Axial Tomography	
<input type="checkbox"/> MUGA Scan*	
<input type="checkbox"/> Pacemaker Insertion – Temporary	
<input type="checkbox"/> SPECT Scan	
<input type="checkbox"/> Stress Test	
<input type="checkbox"/> Treadmill	

Procedure	Estimated # Performed Per Year
(Stress Test Continued)	
<input type="checkbox"/> Myocardial Perfusion Imaging*	
<input type="checkbox"/> Stress Echo	
<input type="checkbox"/> Transesophageal Echocardiography	
<input type="checkbox"/> Transtelephonic Pacemaker Monitoring	
<input type="checkbox"/> Ultrafast CT Scanning	

*If you are performing nuclear cardiac imaging and you have not completed a fellowship in nuclear medicine, please provide proof of the training that you received for this procedure(s).

Invasive Procedures

If you do not perform any of the procedures listed below, please check here.

Procedure	Estimated # Performed Per Year
<input type="checkbox"/> Angiography	
<input type="checkbox"/> Coronary	
<input type="checkbox"/> Noncoronary	
<input type="checkbox"/> Automated Internal Defibrillators*	
<input type="checkbox"/> Biventricular Pacing for Heart Failure*	
<input type="checkbox"/> Cardiac Arrhythmias Regulation – Catheter Ablation*	
<input type="checkbox"/> Catheterization	
<input type="checkbox"/> Left Heart	

Procedure	Estimated # Performed Per Year
(Catheterization Continued)	
<input type="checkbox"/> Noncoronary	
<input type="checkbox"/> Cardiac Resynchronization Therapy*	
<input type="checkbox"/> Electromechanical Mapping of Myocardium*	
<input type="checkbox"/> Electrophysiology Studies*	
<input type="checkbox"/> Intravascular Ultrasound (IVUS)	
<input type="checkbox"/> Pacemaker Insertion – Permanent	

*If you are performing any invasive procedures marked with an asterisk and you have not completed a fellowship in clinical cardiac electrophysiology, please provide your proof of training for each such procedure.

Interventional Procedures

If you do not perform any of the procedures listed below, please check here.

Procedure	Estimated # Performed Per Year
<input type="checkbox"/> Angioplasty	
<input type="checkbox"/> Coronary	
<input type="checkbox"/> Noncoronary or Carotid	
<input type="checkbox"/> Aortic or Mitral Balloon Valvuloplasty	
<input type="checkbox"/> Atherectomy	
<input type="checkbox"/> Automated Implantable Cardioverter – Defibrillator (AICD) Insertion	
<input type="checkbox"/> Balloon Atrial Septostomy	
<input type="checkbox"/> Intravascular Coiling	

Procedure	Estimated # Performed Per Year
<input type="checkbox"/> Coronary Radiation for Restenosis	
<input type="checkbox"/> Direct Myocardial Laser Revascularization	
<input type="checkbox"/> Intracoronary Gene Therapy	
<input type="checkbox"/> Percutaneous Myocardial Revascularization (PMR)*	
<input type="checkbox"/> Pulmonary Balloon Valvuloplasty	
<input type="checkbox"/> Rotablation	
<input type="checkbox"/> Stenting	

*If you are performing PMR and you completed your cardiology residency before 1998, please provide proof of the training that you received for the procedure(s).

2. If you indicated that you are performing interventional procedures and you have not completed a fellowship in interventional cardiology, please provide the following:

- Proof of training and hospital privileges for each interventional procedure that you are performing
- A description of the proctoring procedure used at the hospital, including the credentials of the proctoring physician:

3. Do you perform any procedure(s) not already specified on this questionnaire? Yes No

If yes, please identify the procedure(s):

SECTION II: Remarks

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

For California and Rhode Island Physicians Only

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

Print Name

For Alaska Physicians Only

I represent 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

Print Name