

ENCLOSED IS THE FORM NECESSARY FOR SUBSTITUTE PHYSICIAN (LOCUM TENENS) COVERAGE

- You must be a member of Texas Medical Association or have a membership application pending in order to apply for coverage.**
- You must be a licensed physician in Texas.**
- Complete and sign the *Application for Coverage*.
- Complete the *Claim/Suit Information Addendum* if a professional liability claim or suit has **ever** been brought against you.
- Enclose a copy of your current *Curriculum Vitae*, and a copy of your current *Professional Liability Declarations Page*.
- Enclose a letter from the TMLT physician that requests coverage be added to their policy for substitute coverage and specific dates coverage will be needed.

Please allow 10 days for processing.

If you have any questions, we will be happy to assist you. Call our toll free number listed below and ask for Underwriting.



P.O. Box 160140 • Austin, TX 78716-0140
901 Mopac Expressway South • Barton Oaks Plaza V, Suite 500 • Austin, TX 78746
800-580-8658 • 512-425-5800 • fax: 512-425-5999 • www.tmlt.org



Policy Number (For Trust Use Only)

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INDIVIDUAL APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE SUBSTITUTE PHYSICIAN (LOCUM TENENS)

Please type or print in black ink. All questions must be answered in detail.

I. GENERAL INFORMATION

A. _____ **M.D.** **D.O.**

First Name	Middle Name	Last Name
Home Address	City	State
Date of Birth	# Texas Medical License/Status	# Social Security Number
Office Phone: Area Code Number	Home Phone: Area Code Number	Fax: Area Code Number
Pager: Area Code + Number	Cell Phone: Area Code + Number	Email Address

B. Please list all **Texas hospitals** where you intend to practice.

Hospital Name	City	Type of Privileges
		Full <input type="checkbox"/> Courtesy <input type="checkbox"/> *Restricted <input type="checkbox"/> *Other <input type="checkbox"/>
		Full <input type="checkbox"/> Courtesy <input type="checkbox"/> *Restricted <input type="checkbox"/> *Other <input type="checkbox"/>
		Full <input type="checkbox"/> Courtesy <input type="checkbox"/> *Restricted <input type="checkbox"/> *Other <input type="checkbox"/>

*If Restricted or Other, please provide details on page 6.

C. Are you a member of the Texas Medical Association? Yes No
 If no, since this is a prerequisite for coverage, is your membership pending? Yes No

Name of County Medical Society and date of application _____

D. Do you have current professional liability coverage? Yes No
 If yes, provide the following:

Name of Company	Policy Period	Limits of Liability	Claims-made or Occurrence
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II. UNDERWRITING AND RATING INFORMATION

A. Medical Practice History

I. Education

	School/Hospital	City/State	From/To	Degree/Specialty
Medical School				
Internship				
Residency				
Fellowship				

2. a. Did you complete residency training? Yes No

b. Are you entering practice for the first time immediately following residency training, military service or an academic position? Yes No

3. a. Are you American Board Certified? Yes No

Name of Specialty Board

Date(s) Certified

b. If not certified, are you admissible to a Specialty Board examination? Yes No

Name of Board

Exam Date

c. Have you ever failed to pass a Board exam? Yes No

Name of Specialty Board

Which portion?/Date(s)

d. Are you certified? ACLS ATLS PALS

e. Have you ever been denied a medical license or certification by a Specialty Board? Yes No
If yes, please provide details on page 6.

4. Where have you practiced your profession since completion of your formal training? (Include military or any public service organization.) PLEASE ACCOUNT FOR ALL TIMES SINCE COMPLETION OF MEDICAL SCHOOL, WITH THE EXCEPTION OF YOUR RESIDENCY OR FELLOWSHIP TRAINING. INCLUDE YOUR SPECIALTY AT THAT TIME.

Specialty	City	State	Country	From Month	/	Year	To Month	/	Year
Specialty	City	State	Country	From Month	/	Year	To Month	/	Year
Specialty	City	State	Country	From Month	/	Year	To Month	/	Year
Specialty	City	State	Country	From Month	/	Year	To Month	/	Year
Specialty	City	State	Country	From Month	/	Year	To Month	/	Year

II. UNDERWRITING AND RATING INFORMATION CONTINUED

B. Medical Practice Description

1. What is your Medical Specialty? _____

2. Please check any of the following procedures you perform:

Biopsy		ERCP's	<input type="checkbox"/>	Saline Breast Implants	<input type="checkbox"/>
Breast	<input type="checkbox"/>	Esophageal Gastro Dilatation	<input type="checkbox"/>	Silicone Breast Implants	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	Liposuction	<input type="checkbox"/>	Silicone Injections	<input type="checkbox"/>
Liver	<input type="checkbox"/>	Percutaneous Gastrostomy	<input type="checkbox"/>	Spinal Surgery	<input type="checkbox"/>
Lung	<input type="checkbox"/>	Percutaneous Transhepatic		Tubal Ligations	<input type="checkbox"/>
Prostate	<input type="checkbox"/>	Cholangiography	<input type="checkbox"/>	Vasectomies	<input type="checkbox"/>
Cardiac Catheterization	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>		
Endoscopic Sclerotherapy	<input type="checkbox"/>				

3. Will you perform minor surgery other than the incision of boils, suturing of skin or superficial abscesses? (includes most procedures performed under a local anesthetic) Yes No

4. Will you perform major surgery? (includes tonsillectomies, adenoidectomies, D&C's, cesarean sections, abortions and open fractures) Yes No

5. Will you assist in major surgery? Yes No

6. Will you perform major surgery in a freestanding facility or an office? Yes No

7. Will you perform weight control surgery? Yes No

8. Will you perform pain management procedures in an office? Yes No

9. Will laser equipment be utilized in the practice(s)? Yes No

10. Will you perform plastic surgery? Cosmetic: Yes No
Reconstructive: Yes No

11. Will you perform cosmetic/aesthetic procedures? Yes No

12. Will you perform telemedicine? _____ % Yes No

If you answer yes to questions 13-29, please provide details on page 6.

13. Will you dispense or prescribe medications or use medical devices which are disapproved by the FDA in the treatment or care of human beings? Yes No

14. Have you ever been treated for alcoholism or substance abuse? Yes No
If yes, provide details and a recent statement of insurability from your treating physician.

15. Have you now or ever had any chronic illness, mental illness or physical defect? Yes No
If yes, provide details and a recent statement of insurability from your treating physician.

16. Has your medical license or permit to prescribe drugs ever been under investigation or voluntarily surrendered? Yes No

17. Has your medical license or permit to prescribe drugs ever been denied, restricted, revoked, suspended, or cancelled? Yes No

18. (a) Has any hospital or clinic ever denied, restricted, suspended, or revoked your privileges? Yes No

(b) Are you currently under investigation? Yes No

(c) Have you ever resigned from a hospital, clinic, or other facility during or following a medical staff investigation? Yes No

II. UNDERWRITING AND RATING INFORMATION CONTINUED

19. Has your membership in any professional society or association ever been denied, cancelled, revoked, or censured? Yes No
20. Have you ever been indicted, charged or convicted of a crime other than a minor traffic violation? Yes No
21. Have any fee complaints or professional relations complaints ever been made against you with your medical association, hospital or licensing authority? Yes No
22. Have Medicare/Medicaid or their authorities ever brought charges against you for alleged fraud or inappropriate fees? Yes No
23. Have you ever appeared before a state regulatory or review committee for alleged misconduct or malpractice? Yes No
24. Has your professional liability insurance ever been denied, restricted, surcharged, cancelled or non-renewed? If yes, please explain why, when and name of insurer(s). Yes No
25. Are you aware that your present insurer plans to restrict, surcharge, cancel or non-renew your coverage? Yes No
26. Are you aware of any incidents (patient expressions of dissatisfaction or fee disputes resulting from treatment rendered) which you have reason to believe may lead to a claim or suit against you? Yes No
27. Have you reported any incidents (which have not yet resulted in a claim or suit) to another insurance carrier? Yes No
28. Have you received any oral or written threats of legal action, attorney's request for patient records, subpoena, petition, complaint, summons, citation or other legal process or notification? Yes No
29. How many professional liability claims have **ever** been brought against you? # _____
This includes notice of intent to sue, written demand from a patient or lawsuit.
Complete the information for all claims/suits on pages 6-7.

III. AUTHORIZATION AND WARRANTY STATEMENT

I warrant and represent that the foregoing information in this application is true and correct. I understand that this application is not a binder or acceptance of coverage, and that if any coverage is issued, this application and the statements therein, become part of that policy. I further understand and agree (1) that any coverage shall be issued in reliance upon the warranties and representations made herein; (2) if this application contains any false statements, the intent to deceive will be presumed; (3) any false statement or concealment will void all coverage. Please be aware this application may be available for review by your opponent in any future legal proceeding.

All potential claims or lawsuits have been disclosed herein and have been reported to the applicable, prior professional liability insurance carrier. **I understand any policy issued by TMLT will exclude coverage for any claim or lawsuit which may arise out of any incident of which I am aware and have reason to believe may lead to a claim or suit.**

I authorize access by, and release to, TMLT any and all information of an underwriting and/or claims nature pertaining to the undersigned applicant in the possession, custody, or control of any of the following: Texas Medical Board; any other licensing agency; Texas Medical Association; any other state medical association or organization; any county medical society; any specialty medical society or organization; any hospital medical staff or committee; and any insurance carrier that has previously insured or been requested to insure the undersigned applicant with respect to Medical Professional Liability and/or Premises Liability Coverage. I further authorize TMLT and its representatives to contact such groups or any other group or individual for the purpose of discussing or obtaining information concerning underwriting or claims matters pertaining to the undersigned. I agree to provide any written authorization required to obtain this information. I recognize that such information may be otherwise privileged or confidential and I hereby release from liability all individuals and organizations who provide this information.

By submission of this application, or by acceptance of coverage from TMLT, I hereby release TMLT and its representatives from liability for any acts or omissions in connection with communications, investigations or underwriting decisions.

Physician's Signature

Date Signed

THIS IS NOT A BINDER OR ACCEPTANCE OF INSURANCE

**Coverage will not be considered until this application is completed, signed and dated.
Failure to provide complete information/attachments as requested will cause delay.**

ENCLOSE a copy of your current **Curriculum Vitae** and a copy of your current Professional Liability **Declarations Page**.

V. CLAIM/SUIT INFORMATION ADDENDUM CONTD.

2. CLAIM/SUIT INFORMATION

Patient's name: _____ Age: _____ Sex: _____ Date of incident: _____
Month/Day/Year

Insurance company defending your claim: _____

Location: City _____ State _____ Hospital _____

ALLEGATIONS and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.) Please attach a second sheet of paper if additional space is required:

Co-defendants: _____

Claim is pending: Yes No

Lawsuit filed: Yes No If Yes: Month _____ Year _____

Court Trial: Yes No Jury verdict: Yes No

Settled without indemnity payment on your behalf? Yes No

Settlement out of court: Yes No If Yes: Month _____ Year _____

Total amount paid to claimant on **your** behalf: \$ _____

Total amount paid to claimant for **all** defendants: \$ _____

3. CLAIM/SUIT INFORMATION

Patient's name: _____ Age: _____ Sex: _____ Date of incident: _____
Month/Day/Year

Insurance company defending your claim: _____

Location: City _____ State _____ Hospital _____

ALLEGATIONS and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.) Please attach a second sheet of paper if additional space is required:

Co-defendants: _____

Claim is pending: Yes No

Lawsuit filed: Yes No If Yes: Month _____ Year _____

Court Trial: Yes No Jury verdict: Yes No

Settled without indemnity payment on your behalf? Yes No

Settlement out of court: Yes No If Yes: Month _____ Year _____

Total amount paid to claimant on **your** behalf: \$ _____

Total amount paid to claimant for **all** defendants: \$ _____