TMLT
Texas Medical Liability Trust

TEXAS MEDICAL LIABILITY TRUST

P.O. Box 160140 • Austin, TX 78716-0140 • 800-580-8658 • 512-425-5800 • fax: 512-425-5998 • sales@tmlt.org

COSMETIC/AESTHETIC QUESTIONNAIRE FOR PROFESSIONAL LIABILITY COVERAGE

PLEASE RETURN THE QUESTIONNAIRE WITHIN 14 DAYS.

POLICY NUMBER _____
(For Trust Use Only)

First name _____ Middle name _____ Last name _____ Office phone _____

1. What percentage of your practice is dedicated to cosmetic/aesthetic procedures? _____ %

   Please advise how many years you have performed cosmetic/aesthetic procedures? _____

2. Please check off any of the following procedures performed and the number per year:

You	Staff	Procedure	# per year	You	Staff	Genital Cosmetic Surgery	# per year
☐	☐	Laser Skin Rejuvenation		☐	☐	Hymenoplasty	
☐	☐	Laser Hair Removal		☐	☐	Vaginoplasty	
☐	☐	Laser Scar/Tattoo Removal		☐	☐	Clitoraplasty	
☐	☐	Hair Restoration/Transplant		☐	☐	Labiaplasty	
☐	☐	Chemical Peel		☐	☐	Phalloplasty	
☐	☐	Varicose Vein Treatment		☐	☐	Laser Vaginal Rejuvenation	
☐	☐	Liposuction/Sculpting/Dissolve		☐	☐	Other:_____	
☐	☐	Permanent Makeup					
☐	☐	Non-Surgical Facelift/Skin Tightening					
☐	☐	Eyelid Surgery					
☐	☐	Implants					
☐	☐	Other: _____					

   Is a written Informed Consent obtained from the patient prior to the procedure? ☐ Yes ☐ No

3. Do you utilize specific screening procedures to determine the appropriate candidates for surgery? ☐ Yes ☐ No

4. Do the ancillary staff who are performing aesthetic/cosmetic procedures have professional liability coverage? ☐ Yes ☐ No

   If yes, please provide the name of the insurance carrier: _____

   Limits of liability: _____

5. Have you or your staff completed any cosmetic/aesthetic related CMEs, training or certification? ☐ Yes ☐ No
   If yes, please provide documentation for the past twelve (12) months.

6. Do you perform cosmetic/aesthetic revisions? ☐ Yes ☐ No
   If yes, how many do you perform a year on: Referred patients: _____ Own patients: _____

7. Was training provided by the manufacturer on the specialized equipment used to perform cosmetic/aesthetic procedures? ☐ Yes ☐ No
   Please provide the name(s) of the equipment below.

_____

_____

_____

Section II – Please list the name of the location, the anesthesia provided, basic life support equipment and the website at each facility where you provide cosmetic/aesthetic services. **If additional space is needed, please photocopy this form as needed.**

Facility/Location Information

a. _____ ☐ Office/Clinic ☐ Surgical Center ☐ Hospital
Name

☐ You ☐ Other Physician ☐ Other Professional
_____
Supervisor Name

_____ _____
Supervisor Insurance Carrier Limits of liability

b. Please indicate the type(s) of anesthesia provided.
☐ Oral ☐ Intramuscular Sedation ☐ Intravenous Sedation ☐ General Anesthesia ☐ Tumescent Anesthesia
☐ Other: _____

☐ You ☐ Other Physician ☐ Other Professional
_____
Provider Name:

_____ _____
Provider Insurance Carrier Limits of liability

c. In case of an emergency situation, please check all types of basic life support/resuscitative equipment available:
☐ Crash Cart ☐ Defibrillator ☐ ER Pharmaceutical Kit ☐ Oxygen Mask ☐ Pulse Oximeter
☐ Other: _____

d. If you advertise or have a website related to these procedures please list it below.

_____

Facility/Location Information

a. _____ ☐ Office/Clinic ☐ Surgical Center ☐ Hospital
Name

☐ You ☐ Other Physician ☐ Other Professional
_____
Supervisor Name

_____ _____
Supervisor Insurance Carrier Limits of liability

b. Please indicate the type(s) of anesthesia provided.
☐ Oral ☐ Intramuscular Sedation ☐ Intravenous Sedation ☐ General Anesthesia ☐ Tumescent Anesthesia
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☐ You ☐ Other Physician ☐ Other Professional
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Provider Name:

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c. In case of an emergency situation, please check all types of basic life support/resuscitative equipment available:
☐ Crash Cart ☐ Defibrillator ☐ ER Pharmaceutical Kit ☐ Oxygen Mask ☐ Pulse Oximeter
☐ Other: _____

d. If you advertise or have a website related to these procedures please list it below.

_____

I hereby warrant and represent that the foregoing information is true and correct. I understand and agree that this questionnaire and the statements therein become a part of the policy. I further understand and agree (1) that any policy shall be issued in reliance upon the warranties and representations made herein; (2) if this questionnaire contains any false statements, the intent to deceive will be presumed; (3) any false statement or concealment will void all coverage.

_____ _____
Physician Signature Date