TEXAS MEDICAL LIABILITY TRUST

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PAIN MANAGEMENT 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. Do you perform pain management procedures in an office/clinic setting other than your own? ☐ Yes ☐ No
   If yes, please provide the name and location. ____________________

2. Do you perform pain management procedures in an ambulatory surgery center? ☐ Yes ☐ No
   If yes, please provide the name and location. ____________________

3. Do you perform pain management procedures in a hospital setting? ☐ Yes ☐ No
   If yes, please provide the name and location. ____________________

4. Have you completed a pain management fellowship program? ☐ Yes ☐ No
   If no, please provide documentation of training and related CME for the last twelve months.

5. Please list the pain management procedures you perform, including the number performed each year.

   Type of procedure: ____________________ # performed each year: __________

   Type of procedure: ____________________ # performed each year: __________

   Type of procedure: ____________________ # performed each year: __________

6. In case of an emergency situation, please check all types of basic life support/resuscitative equipment available in your office/clinic setting or ambulatory surgical center including, but not limited to:

   ☐ Crash cart ☐ Defibrillator ☐ ER pharmaceutical kit ☐ Oxygen mask ☐ Pulse oximeter

   Other equipment: ____________________

7. Are you and/or a member of your staff currently certified in the following?
   Physician: ☐ ACLS ☐ ATLS ☐ PALS Staff: ☐ ACLS ☐ ATLS ☐ PALS

8. Do you and your staff conduct simulated emergency training on a regular basis? ☐ Yes ☐ No

9. Please list the name of the nearest hospital and its proximity to your office.

   Hospital Name: ____________________ # of miles: __________

10. Please provide any additional information or clarification regarding your pain management practice.

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's Signature

____________________ Date