



TEXAS MEDICAL LIABILITY TRUST

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BARIATRIC 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. Please list all the locations where bariatric surgeries are performed.

Name of facility City State Credentialed for: [] Banding [] Bypass

2. Have you completed a fellowship program in bariatric surgery? [] Yes [] No

If no, please provide additional information: a. How many hours of training were completed? b. How many gastric banding procedures did you perform as: First assist surgeon: Primary surgeon: c. How many gastric bypass procedures did you perform as: First assist surgeon: Primary surgeon:

3. Have you completed any bariatric related CMEs? [] Yes [] No

4. Do you perform gastric banding procedures? If yes, how many do you perform per year? [] Yes [] No

5. Do you perform gastric bypass procedures? If yes, how many do you perform per year? [] Yes [] No

6. Do you perform bariatric surgery revisions? [] Yes [] No

7. Are you currently board certified in bariatric surgery? [] Yes [] No

8. Have you completed the Bariatric Surgery Center of Excellence (BSCOE) program? [] Yes [] No

If no, do you provide the following: a. [] Health assessment [] Psychological assistance [] Staff experienced in bariatric care [] Cardiac work-up [] Patient support groups [] Appropriate equipment and instruments [] Dietary instruction [] Qualified call coverage [] Facility licensing and accreditation [] Counseling [] Clinical pathways and standardized operating procedures b. Do you utilize specific screening procedures to determine the appropriate candidates for surgery? [] Yes [] No c. Do you have a patient follow-up program in place to prevent, monitor and manage short-term and long-term complications? [] Yes [] No

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