f previously covered with Medio	cal Protective, please
enter the policy number:	

Start Date:

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THE MEDICAL PROTECTIVE COMPANY PHYSICIAN PROFESSIONAL LIABILITY INSURANCE APPLICATION

For faster service, please enter your application online at WWW.MEDPRO.COM

Application Instructions A. If additional space is needed, please complete Section X. Supplemental Information with a reference to the question. B. Additional documentation may be requested by the company as necessary. For example: A copy of your most recent professional liability policy, including all endorsements, Declarations Page, etc. C. Please print legibly. Please answer all questions; if a question is not applicable, state "N/A". I. General Information A. Last Name First Name (Full) Male Female Middle Name Suffix Date of Birth MM/DD/YYYY Social Security Number (Optional) National Provider Identifier Number **Business Phone** Business Fax Email address: B. If you have a web address, please provide the website address (URL): C. Residence Address: Number & Street Apartment # City State Zip Code County D. Practice Locations: (Please list primary location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.) Office Hospital Other If other please explain: % of practice Practice/Hospital Name Number & Street City Suite Zip Code Start Date: County Office Hospital Other If other please explain: % of practice Practice/Hospital Name Number & Street City State Zip Code Suite

County

I. Genera	al Illiorni	ation (COILLI	iueu)																													
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		Count	<u> </u>								Ш			Ш												Start	Date		IM		YYYY		╛
E. Do yo	u admit _l	atient	ts to a	ny of t	the at	ove	hosį	oital	loca	tions	s?																			,	Yes	N	0
If no, p	please exp	lain yo	ur proto	ocol to	admit	patie	ents t	o a h	ospit	al if t	he ci	rcun	nstan	ice w	vould	arise	е.																_
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2.																																	
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1. Name of Hospital/Facility/Program City State Country Specialty Type Completed?	YY Yes No Yes No Yes No
Name of Hospital/Facility/Program City State Country Specialty Type Completed?	YY Yes No Yes No Yes No
Specialty Type Completed?	YY Yes No Yes No Yes No
Specialty Type Completed?	YY Yes No Yes No Yes No
Completed? Yes No Still in training From: /	YY Yes No Yes No Yes No
Completed? Yes No Still in training From: /	YY Yes No Yes No Yes No
2. Name of Hospital/Facility/Program City State Country Specialty Type Completed? Yes No Still in training From: MM / YYYY To: MM / YYYY D. Are you entering private practice for the first time? E. If you have participated in continuing medical education within the last three (3) years, indicate the number of Category 1 or F. Have you completed a risk management education course within the last twelve (12) months?	YY Yes No Yes No Yes No
2. Name of Hospital/Facility/Program City State Country Specialty Type Completed? Yes No Still in training From: MM / YYYY D. Are you entering private practice for the first time? E. If you have participated in continuing medical education within the last three (3) years, indicate the number of Category 1 or F. Have you completed a risk management education course within the last twelve (12) months?	YY Yes No Yes No Yes No
City Specialty Type Completed?	Yes No Yes No Yes No
Specialty Type Completed? Yes No Still in training From: MM / YYYY To: MM / YYYYY D. Are you entering private practice for the first time? E. If you have participated in continuing medical education within the last three (3) years, indicate the number of Category 1 or F. Have you completed a risk management education course within the last twelve (12) months?	Yes No Yes No Yes No
Completed? Yes No Still in training From: MM / YYYY To: MM / YYYYY D. Are you entering private practice for the first time? E. If you have participated in continuing medical education within the last three (3) years, indicate the number of Category 1 or F. Have you completed a risk management education course within the last twelve (12) months?	Yes No Yes No Yes No
D. Are you entering private practice for the first time? E. If you have participated in continuing medical education within the last three (3) years, indicate the number of Category 1 or F. Have you completed a risk management education course within the last twelve (12) months?	Yes No Yes No Yes No
E. If you have participated in continuing medical education within the last three (3) years, indicate the number of Category 1 c F. Have you completed a risk management education course within the last twelve (12) months?	1 credit hours.
F. Have you completed a risk management education course within the last twelve (12) months?	Yes No
	r primary Yes No
III. Practice Information	r primary Yes No
A. Do you perform consultations, render medical services, medical opinions, or give medical advice outside the state of your pr location, including, but not limited to, Telemedicine or Internet Medicine? (If this is covered by another professional liability insurance policy, complete Section IV., Question H.)	
If yes, which state(s):	
B. States in which you hold a license to practice medicine: Please check the appropriate box to indice.	ndicate the status of your license.
	Temporary Pending
1. State License #	
2. State License #	
3. State License #	
4. State License #	
C. Do you have previous practice location(s)? If yes, list all location(s) within the past 10 years. If your requested retroactive of than 10 years, provide locations back to the retroactive date. Please list most recent location first.	ve date is greater Yes No
1.	
Name of Practice	
City State Country State Country To:	To: /
	To:
Specialty 2. Name of Practice	
Specialty 2. Name of Practice City State Country From: /	MM YYYY
Specialty 2. Name of Practice City State Country Specialty From: /	MM YYYY
Specialty 2. Name of Practice City State Country Specialty D. Please explain the following gaps if they occurred in the last 10 years:	MM YYYY
Specialty 2. Name of Practice City State Country Specialty From: /	MM YYYY
Specialty 2. Name of Practice City State Country Specialty D. Please explain the following gaps if they occurred in the last 10 years:	MM YYYY

III. Practice Information (continued)		
Note: All percentages requested below for specialties, procedur	es and surgical activities are of your total practice.	
**Please enter complete name of specialty/sub-specialt	-	
	, , ,	1 1 1
F. What is your present specialty?		% of total practice
What is your sub-specialty?		% of total practice
What is your sub-specialty?		96 of total practice
G. Are you permanently retired from the practice of clinical	medicine? Yes No	
H. American Board Certified? Yes No		
II. American Board Certified:	Specialty Board	Date most recently certified
<u>-</u>		
	Specialty Board	Date most recently certified
If not American Board Certified, are you board eligible?	Yes No If yes, when do you plan on taking your bo	pards?
		MM YYYY
If not American Board Certified, have you ever taken a specialty	board examination and failed to pass?	∐ No
If yes, how many times?		
If yes, please explain:		
I. Indicate the estimated average weekly numbers, under	each of the following categories, for which you require	Medical Protective coverage.
Hours per week Patients seen per week	None Unscheduled walk-in	None
	patients per week	
J. Please check any of the following procedures you will pe	erform:	
Abdominoplasty - Tummy Tuck	□ D & C	Pacemakers - Epicardial
Abortions- Elective% of total practice	Discectomy	Pacemakers - Endocardial
Abortions- Therapeutic% of total practice	Open	Pacemakers - Temporary
Acupuncture - Therapeutic/Local Anesthetic	U Other Than Open	Peritoneoscopy
Anesthesia General/Spinal/Caudal	☐ Electromagnetic Therapy	Phlebography
Angiography	Electroconvulsive/Shock Therapy	Pneumoencephalography
Angioplasty	Embolization	Polypectomy
Arteriography	☐ ERCP	Prenatal /Gynecological Practice
Arthroscopy	Face Lifts Mini (done with lacer) 9/4 of total practice	Prenatal Practice - 1st & 2nd Trimester
Assisting in major surgery - own patients only	Face Lifts Mini (done with laser)% of total practice Gastrointestinal Endoscopy	Prenatal Practice - to term, no delivery
Assisting in major surgery - own & other than own patients	Gynecology - Major Surgery	Prenatal Practice - to term, and delivery
Bariatric Surgery - Laparoscopic	Hair Transplants - Follicular Unit Transplantations	Normal Deliveries - total per year
Bariatric Surgery - Non-Laparoscopic	Hair Transplants - Other	Cesarean Deliveries - total per year
Biopsy - Endoscopic	HVLA on the cervical spine on patients	Prolotherapy
Blepharopigmentation % of total practice	younger than 18 years of age	Radial/Laser Keratotomy
Blepharoplasty - Cosmetic % of total practice	Intrathecal Pumps	Radiation/X-Ray Therapy
Blepharoplasty - Reconstruction % of total practice	Kyphoplasty	Rectal Ozone Therapy
Botox % of total practice	Laporoscopic Cholecystectomy	Rhinoplasty% of total practice
Brachioplasty	Laparoscopy	Sigmoidoscopy - 60 cm or less
Breast Implants - Cosmetic % of total practice	Laser Surgery	Sigmoidoscopy - greater than 60 cm
Breast Implants - Reconstruction % of total practice	Laser Therapy (Endoscopic)	Silicone Injections % of total practice
Breast Reduction - Cosmetic	Laser Therapy (Non-Endoscopic)	Skin Flaps/Grafts
Bronchoscopy	Lipoinjection% of total practice	Cosmetic% of total practice
Bronco-esophagology	Liposuction Other Than Tumescent Technique	Reconstruction% of total practice
Buttock Implants	Other Than Tumescent Technique	Spinal Cord Stimulators
Calf Implants	Tumescent Technique Only% of total practice Lithotripsy	Thigh Lift
Cataract Surgery	Lymphangiography	Tubal Ligations
Catheterization - Left Heart	Mammograms	Upper GI Endoscopy
Catheterization - Right Heart (other than CVP lines)/	Myelography	Vasectomies - own patients
Swan Ganz	Nerve Blocks	Vasectomies - own & other than your
Cheek/Chin/Lip Implants	Facet	own patients
Chelation Therapy	Lumbar Epidural Steroid	Weight Control Medication
Chemical Peels - Superficial / Medium	Myofascial	% of total practice
Chemical Peels - Deep% of total practice	Occipital	Other Medical Techniques
Cleft Lip Surgery - Reconstructive	Paraspinal/Paravertebral	List Procedures (do not restate your specialty)
Cleft Palate Surgery - Reconstructive	Peripheral	
Colonoscopy	Sciatic	
Cryosurgery (Cervical)	Triggerpoint Injection	
Cryosurgery (cervical) Cryosurgery (non-external lesions)	Oxidation Therapy	
S., SSG ger, (Non external residus)		

III. Practice Information (continued) K. Please indicate the percentage of your total practice performing the following surgical activities:	
% Cardiac % Orthopedic (including back)	
% Gynecology % Orthopedic (not including back)	% Traumatic
% Hand % Otolaryngology	% Urology
% Neurosurgery % Plastic (cosmetic enhancement only)	% Vascular
% Obstetrics % Plastic (reconstruction only)	% Other (Describe)
% Ophthalmology	
L. In the last 10 years,1. Have you discontinued major surgical procedures, performance of obstetrics, or any other medical activity?	Yes No
If yes, list procedures/activities, reason for discontinuing, and date discontinued.	Date: /
, ., ., .,,	MM YYYY
2. Have you performed weight control surgery or prescribed weight control medication?	☐ Yes ☐ No
a. If yes, what percentage of your practice (% of patient care) was devoted to prescribing anorectic drugs?	
☐ <1% ☐ 1% - 10% ☐ 11%-50% ☐ >50% ☐ Never prescribed weight control	
b. If yes, what percentage of your practice (% of patient care) was devoted to performing weight control surg	•
M. Do you have ownership or financial interests in a weight control clinic?	Yes No
If yes, what is the name of the weight control clinic with which you are affiliated?	
N. Do you work in an emergency room on a scheduled basis? (If yes, answer 1 and 2 below.)	Yes No
1. Indicate average number of hours per month devoted to in-hospital emergency room care. (Do not include on-cal	l hours.)
2. On average how many of the above hours are you working in order to fulfill staff privilege requirements?	
(If you have emergency room activities which are covered by another professional liability insurance policy, please	e complete Section IV. Question H.)
O. Please use the space below for any comments you feel will help The Medical Protective Company better	,
O. Please use the space below for any comments you feel will help The Medical Protective Company better your practice.	,
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your practice. IV. Additional Professional Information	understand any special circumstances concerning
your practice. IV. Additional Professional Information Please fully explain any "yes" answer in Section X. Supplemental Information with a reference to the quest	r understand any special circumstances concerning
IV. Additional Professional Information Please fully explain any "yes" answer in Section X. Supplemental Information with a reference to the quest (For questions A through G, please complete Section IV., Question H, if you are covered by other insurance for these	tion.
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Note that the procession of the content of the co	IV. Additional Profession	al Information (con	tinued)			
Practice Name: Location:	H. Will you be performing	activities which wi	I be covered by another profession	onal liability policy?		Yes No
Location: Name of Insurer: I. size you sever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offences or had your hospital privileges. Ell license, medical license or reimbursement privileges refused, denied, revoked, suspect to a reprimand, placed on probation or voluntarily surrendered? If yes, please indicate the date(s) and explain: Date: MM YYYY J. Issa any professional liability insurance company ever declined, retused, canceled, or non-renewed your coverage or have you ever had Yes No an involuntary deductible or surcharge assessed against your policy? If yes, please indicate the date(s) and explain: Date: MM YYYY C. Have you ever been accused of sexual misconduct of any kind? If yes, please indicate the date(s) and explain: Date: MM YYYY Lives, please indicate the date(s) and explain: Date: MM YYYY Lives, please indicate the date(s) and explain: Date: MM YYYY Lives, please indicate the date(s) and explain: Date: MM YYYY Lives, please indicate the date(s) and explain: Date: MM YYYY Lives, please indicate the date(s) and explain: Date: MM YYYY Lives, please indicate the date(s) and explain: Date: MM YYYY Lives, please indicate the date(s) and explain: Date: MM YYYY Lives, please indicate the date(s) and identify your beliet physicians, to in the event of any such impairment, a statement from your physician attesting to your fitness to practice your speciality must accompany, this application. Type(s) of liness: Date(s) of treatment(s): From: MM YYYY Lives Information (Important Please fully complete) lease complete the Loss Information Supplement for each written request, incident, claim or suit (A, B or C) below that has NOT been covered by a Medical Protective policy, aport professional liability and malpractice related matters including, but not limited to, board complaints, etc. or Questions 8 and C below, report all matters that might reasonably result in a claim or suit against you? If ye	If yes, are you a(n):	Employee	Independent Contractor	Resident/Fellow	Faculty	
Name of Insurer: 1. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges, DEA license, medical license or reimbursement privileges refused, denied, revoked, law or ordinance other than traffic offenses or had you hospital privileges, DEA license, medical license or reimbursement privileges refused, denied, revoked, law or ordinance other than traffic offenses or had you hospital privileges, DEA license, medical license or reimbursement privileges refused, denied, revoked, law or ordinance ordin	Practice Name:					
I. Have you ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance other than traffic offenses or had your hospital privileges. DEA license, medical license or reimbursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? If yes, please indicate the date(s) and explain: Date:	Location:					
traffic offenses or had your hospital privileges, DEA license, medical license or reinhursement privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? If yes, please indicate the date(s) and explain: Date:	Name of Insurer:					
1. Has any professional liability insurance company ever declined, refused, canceled, or non-renewed your coverage or have you ever had Yes No an involuntary deductible or surcharge assessed against your policy? If yes, please indicate the date(s) and explain: Date: MM YYYY C. Have you ever been accused of sexual misconduct of any kind Yes No If yes, please indicate the date(s) and explain: Date: MM YYYY C. Have you ever been accused of sexual misconduct of any kind Yes No If yes, please indicate the date(s) and explain: Date: MM YYYY C. Have you ever been accused of sexual misconduct of any kind Yes No L. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty? Yes No L. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty? Yes No If yes, state condition(s) and date(s) and identify your treating physician(s) in the space provided below. In the event of any such impairment, a Statement from your physician attesting to your fitness to practice your specialty must accompany this application. Type(s) of illness: Date(s) of treatment(s): From:	traffic offenses or had	your hospital privile	ges, DEA license, medical license	or reimbursement privile		Yes No
If yes, please indicate the date(s) and explain:	If yes, please indicate the	e date(s) and explain:				
MM	• •	•		nceled, or non-renewed y	our coverage or have you ever had	Yes No
If yes, please indicate the date(s) and explain: Date: MM	If yes, please indicate the	e date(s) and explain:				
L. Have you ever incurred or become aware of having a condition that impairs your ability to practice your medical specialty? (i.e. convulsive disorders, mental illness, multiple sclerosis, addiction of alcohol, narcotics or other controlled substances, etc.) If yes, state condition(s) and date(s) and identify your treating physician(s) in the space provided below. In the event of any such impairment, a statement from your physician attesting to your fitness to practice your specialty must accompany this application. Type(s) of illness: Date(s) of treatment(s): From: MM / YYYY To: MM / WYYY To: MM / YYYY To: MM / YYYY To: MM / YYYY To: MM / YYYY To: MM / YYYY To: MM / YYYY To: MM / YYYY To: MM / YYYY To: MM / YYYY To:	ር. Have you ever been ac	cused of sexual mis	conduct of any kind?			Yes No
(i.e. convulsive disorders, mental illness, multiple sclerosis, addiction of alcohol, narcotics or other controlled substances, etc.) If yes, state condition(s) and date(s) and identify your treating physician(s) in the space provided below. In the event of any such impairment, a statement from your physician attesting to your fitness to practice your specialty must accompany this application. Type(s) of illness: Date(s) of treatment(s):	If yes, please indicate the	e date(s) and explain:				
Type(s) of illness: Date(s) of treatment(s): From: /						Yes No
Name of treating physician(s): Address(es): Loss Information (Important! Please fully complete.) Los	Type(s) of illness:					
Name of treating physician(s): Address(es): Address(es):	Date(s) of treatme	nt(s): From:		/ <u> </u>	Currently in treatment	
Loss Information (Important! Please fully complete.) lease complete the Loss Information Supplement for each written request, incident, claim or suit (A, B or C) below that has NOT been covered by a Medical Protective policy. deport professional liability and malpractice related matters including, but not limited to, board complaints, etc. or Questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit. A. Are you now, or have you ever been involved, in a claim or suit arising out of the rendering or failure to render professional services? If yes, how many?	Name of treating p	hysician(s):	PIN TITE PIN	1111		
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Claims-Made cove	rage is generally limited to liab	ility for injuries f	or which cla	ims are firs	st made	during	the pol	icy peri	od, fo	r servic	es rende	red betw	een th
	nd expiration date of the policy nce coverage or the additional			-			-		ng to	the diff	erences	between	Claim
2. Requested limits a	nd/or policy types may not be	available in all st	ates.										
. Coverage Desired:													
=	overage without Prior Acts coverage	е		Occurrence	-								
Claims-Made c	overage with Prior Acts coverage			Occurrence	coverage	e with Pr	ior Acts	coverag	e	1 1			
•	ge Period (12:01 am): ill begin and end on the same mont	th and day.	Fre	om: MM	/ DD	/	YYY		То:	MM ,	DD	/ YYYY	
	te shown on your current Claim I for Occurrence with Prior Acts or C			MM	/ DD	/	YYY						
. Desired Limits:	Per Occurrence/Per Claim Filed			Annua	al Aggrega	ato							
	ofessional liability insurers wit	hin the past 10 v	ears. If vour				e is are	ater th	′ an 10	vears,	_ provide :	previous	
	our requested retroactive date.	,					J			,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
1. Current Insurer:											_		
Occurrence	Claims-Made	From: MM	/ <u>DD</u> /	YYYY		To:	/ IM	DD	/ YY	Y			
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·. Piease expiain any	gaps in coverage within the pa	ast 10 years. If yo	our requeste	d retroacti	ve date	is great	er than	10 yea	ırs, pl	ease ex	plain an	/	
gaps back to your	requested retroactive date.									ease ex	plain an		
. If "Occurrence" or recent prior cover	"Claims-Made coverage withous ge was issued on a Claims-Maxtended reporting endorsement (taixtended reporting endorsement has	ut Prior Acts cove de basis, please c il coverage) has bec s not and will not be	rage" was somplete one en or will be per purchased.	elected as e of the foll urchased.	the desi lowing:	red cov	erage a	nd the	most		plain an		
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IX. Notices and Agreements

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (hereinafter "Attachments") for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any Attachments, shall be the basis of the contract with The Medical Protective Company (the "Company"). I agree to notify the Company if there are any future material changes in any answer to this application, or its Attachments, including without limitation, any change in my professional specialty, affiliation or working arrangement with any other dentist, physician, firm or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and void and without effect or provide the Company the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I understand and agree that my credit report and/or my credit score may be obtained, reviewed or used in connection with my submission of this application. I further understand and agree that my credit information may be used to develop a credit-based insurance score, and may also be provided to a third party for the purpose of evaluating my application or to assist in the development of a credit-based insurance score.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Company, in good faith, believes to be applicable	e and pertinent to this application and if issued, the contract of ins	urance issued hereunder.
	Applicant's Signature	Date Signed: MM DD YYYY
	Print Name	
on his or her behalf. I also represent that I have to the best of our combined knowledge and bel and that applicant understands and agrees that	cant's agent: By my signature, I hereby represent that the application reviewed the responses contained in this application with the application, I represent that I have discussed the representations are binding upon him or her, even though sentation or omission made on this application may form the basis	plicant, and we are in agreement they are full and complete tions provided throughout this application with the applicant I am executing this application on the applicant's behalf. I
	Agent's Signature	Date Signed: MM DD YYYY
	Print Name	
. Supplemental Information		

The Medical Protective Company **Loss Information Supplement** Please make copies if additional forms are needed. Applicant's Name: Note: Additional documentation may be requested at The Medical Protective Company's discretion. A \square B \square C \square from the Loss Information section? (Check only one) A. Current or prior claim. B. Complication, incident, or adverse outcome. C. Written request for records. **B. Patient/Claimant Information:** Last Name C. Date of treatment and/or surgery which led, or could lead, to allegations against you. D. Date of notice received, if applicable. E. Has this matter been reported to your current or former insurer? ☐ Yes ☐ No If yes, date reported to your current or former insurer: Current or former insurer name: If no, please explain: F. Name of all other doctor(s), hospital(s), or health care provider(s), if any, involved. Closed **G. Current status:** Open If open, indicate dollar value established by insurer: If closed: 1. Date of closing: Yes No 2. Was a payment made? Yes No a. If yes, did you consent to the settlement? \$ b. Total amount of settlement or award: c. Total amount of settlement or award paid on your behalf: H. Nature of allegations or potential allegations: Condition Treated: Treatment Provided: Alleged Negligence: I. Please provide a narrative description of all relevant facts, including, but not limited to, your involvement in the treatment and/or surgery:

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The Medical Protective Company	
Practice Organization Information Supplement	
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mployment status:	
Employee Shareholder/Partner Independent Contractor Other Date joined: / DD MM DD	/ YYYY
ype of Organization: Standard Medical Practice Hospital State Licensed Medical Surgery Center For use by other physicians Your patients only Other-please explain:	
ntity Name: (As stated in the Articles of Incorporation and all formal entity/clinic names.)	
the above entity does business under any other name, please list all additional entity/clinic names (e.g. DBA, fictitious name, etc.)	
s this entity or employer currently insured with The Medical Protective Company?	Yes No
yes, please provide The Medical Protective Company corporation or partnership policy or group number, if known.	
olicy #: Sub-group #: Sub-group #:	
Shared Policy Limits Separate Policy Limits To request Separate Limit Entity coverage, please contact your agent or MedPro Service Representative to complete an application for consideration.)	
Nurse Midwives Physician Assistants entists Nurse Midwife Assistants Physician Surgical Assistants estheticians Nurse Practitioners Podiatrists ase Managers Nurse Surgical Assistants Psychologists RNAs/RNAs Occupational Therapists Respiratory Therapists o you or any member of your group currently supervise any of the specialists listed above with whom you do not either employ or	
	Practice Organization Information Supplement ype of Legal Entity: (Check only one box) Solo Inicorporated/Sole Proprietor Multi-Shareholder Corporation, Partnership, Limited Liability Company Other-please explain: Impleyee

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