

**RENEWAL APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE**

**Missouri Doctors Mutual Insurance Company** (NAIC #11964)

601 Francis Street, Saint Joseph, Missouri 64501  
 Tel (800) 264-5959 Fax (800) 955-1855



**Before you begin**

- ⌘ Please use black ink when completing this application. Type or print complete answers to every question or write "N/A" for *not applicable*. Failure to provide complete information will delay the processing of this application. Use the 'notes' section to amplify your answers or to provide additional remarks. If you are unsure how to answer a question, call our underwriting department at (816) 676-6363 or (800) 264-5959 between 8:30 AM and 5 PM Monday through Friday.
- ⌘ An attached curriculum vitae will not suffice; this application must be completed.
- ⌘ This completed application, together with any supplementary information, must be personally reviewed, signed and dated in ink by the applicant.

<b>Personal</b>	1	First name	Middle name	Last name	Suffix (Jr./Sr./III)
		Policy number			
<b>Practice Address...</b> <small>If Changed Since Original Application</small>	2	Practice name			
		Street			Suite
		City	State	Zip	County
		Office phone ( ) -	Office fax ( ) -	Office email	
		Contact person		Number of practice locations	
<b>Practice Profile...</b> <small>3-4 If Changed Since Original Application</small>	3	Type of practice (Check one): <input type="checkbox"/> Private practice <input type="checkbox"/> Urgent care center <input type="checkbox"/> Other <i>specify</i> ▶			
		Practicing as (Check one) If you check corporation or partnership or employed physician, please complete information below <input type="checkbox"/> Individual <input type="checkbox"/> Corporation ▼ <input type="checkbox"/> Partnership ▼ <input type="checkbox"/> Employed physician ▼			
		Name			Tax ID number
		Street			Suite
		City	State	Zip	
<b>Employer, Partnership or Corporation Information</b>		Phone ( ) -	Fax ( ) -	Administrator's name (First, Middle, Last)	
		Partner's names		Trade name used (if any)	
	4	If you or your partnership or corporation will employ any paramedical personnel, please provide the census information requested below. If you are practicing as part of a group practice, only one individual (i.e. Corporate Officer or Partner) is required to complete this section on the master application if the information applies to all in the group. ▼			
<b>Paramedical Personnel Census</b>  <small>In the blank space provided enter the number of personnel employed.</small>		_____ Anesthesiologist Assistant♦	_____ Nurse practitioners♦	_____ Physicians—MD's or DO's	
		_____ Certified nurse midwives	_____ Nurses—LPN	_____ Psychologists	
		_____ Dialysis technicians	_____ Nurses—RN	_____ Psychotherapists	
		_____ Inhalation therapists	_____ Opticians	_____ Registered heart/lung perfusionists	
		_____ Laboratory technicians	_____ Optometrists	_____ Surgical assistants	
		_____ Medical assistants	_____ Other employees	_____ X-Ray technicians	
		_____ Nurse anesthetists—CRNA's	_____ Physician assistant♦		

♦ Attach a copy of the collaborative agreement for these specialties.

**Professional Profile...**

5-27

**If Changed Since Original Application**

*Please use the 'notes' section to explain any "Yes" answers in detail.*

5 Primary specialty	% of Practice	Years practicing primary specialty
6	Have you ever been denied board certification or recertification? Yes <input type="checkbox"/> No <input type="checkbox"/>	
7	Has any hospital or other entity ever refused, limited, restricted, suspended, revoked, or is currently investigating a complaint regarding your clinical or staff privileges? Yes <input type="checkbox"/> No <input type="checkbox"/>	
8	Have you ever been investigated by any state licensing board, narcotics board, DEA or other governmental or regulatory agency, or has your license to practice or your state or federal narcotics license ever been denied, restricted, suspended, revoked, voluntarily surrendered or limited in any way? Yes <input type="checkbox"/> No <input type="checkbox"/>	
9	Have you ever been indicted or convicted of a crime other than a minor traffic violation? Yes <input type="checkbox"/> No <input type="checkbox"/>	
10	Have you ever been investigated, suspended, restricted, penalized or put on probation by any governmental health program (for example, Medicare or Medicaid)? Yes <input type="checkbox"/> No <input type="checkbox"/>	
11	Has your membership in any professional society or association ever been refused, censured, suspended or revoked? Yes <input type="checkbox"/> No <input type="checkbox"/>	
12	Has any complaint ever been made against you to any licensing board? (If yes, explain in the notes section the final result of any investigation by that board.) Yes <input type="checkbox"/> No <input type="checkbox"/>	
13	Has a judgement ever been entered against you in a civil lawsuit, other than for medical malpractice? Yes <input type="checkbox"/> No <input type="checkbox"/>	
14	Do you or does your business entity own, operate, manage or participate in any medical enterprise or business? (If yes, please describe in the 'notes' section) Yes <input type="checkbox"/> No <input type="checkbox"/>	
15	Have you ever signed any contractual agreement in which you have agreed to indemnify (hold harmless) other persons or entities? Yes <input type="checkbox"/> No <input type="checkbox"/>	
16	Are you now, or have you ever been, addicted to alcohol, dependent upon narcotic drugs, been afflicted with mental illness, or have you ever received treatment for alcoholism, narcotic addiction or mental illness? Yes <input type="checkbox"/> No <input type="checkbox"/>	
17	Do you have any chronic illness or physical defect that impairs or could impair your ability to practice your specialty? Yes <input type="checkbox"/> No <input type="checkbox"/>	
18	Do you perform surgery—except for incision of boils, suturing of skin or superficial fascia? Yes <input type="checkbox"/> No <input type="checkbox"/>	
19	Do you perform major surgery? (Includes operations in or upon any body cavity including but not limited to, the cranium, thorax, abdomen, or pelvis, or any other operation which, because of the condition of the patient or length of circumstance, presents a distinct hazard to life. It also includes removal of tumors, open fractures, amputation, removal of any gland or organ, plastic surgery, and any other operation done under general anesthesia, and also includes tonsillectomies, adenoidectomies and caesarean sections.) Yes <input type="checkbox"/> No <input type="checkbox"/>	
20	Do you assist—only at surgery? If you answer "Yes", complete the following: ▼ Number of own patients per year? _____ Number of other patients per year? _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	
21	Do you provide any surgical services to patients in any setting in which another person provides the postoperative follow-up care for that procedure? Yes <input type="checkbox"/> No <input type="checkbox"/>	
22	Do you perform general anesthesia? If "Yes", check as appropriate below. ▼ <input type="checkbox"/> Hospital <input type="checkbox"/> Non-hospital facility <input type="checkbox"/> Office Yes <input type="checkbox"/> No <input type="checkbox"/>	
23	Do you supervise CRNA's who provide general anesthesia? Yes <input type="checkbox"/> No <input type="checkbox"/>	
24	Do you perform obstetrical procedures? Yes <input type="checkbox"/> No <input type="checkbox"/>	
25	Do you perform cesarean sections? If "Yes", check as appropriate below. ▼ <input type="checkbox"/> Elective <input type="checkbox"/> Emergency Yes <input type="checkbox"/> No <input type="checkbox"/>	
26	Do you perform abortions? If "Yes", check as appropriate below. ▼ <input type="checkbox"/> First trimester <input type="checkbox"/> Second trimester <input type="checkbox"/> Third trimester Yes <input type="checkbox"/> No <input type="checkbox"/>	
27	Do you practice in an emergency room? If you answer "Yes", complete the following: ▼ Hours per month? _____ Yes <input type="checkbox"/> No <input type="checkbox"/>	

**Professional Profile**

*continued...*

28-30

Please use the 'notes' section to explain any "Yes" answers in detail.

- 28 If you are a radiologist:
- ▶ Is your practice limited to diagnostic radiology? Yes  No
  - ▶ Do you perform radiation therapy or other invasive procedures such as angiography or arteriography? Yes  No
  - ▶ Do you supervise a hospital X-ray lab other than your own? Yes  No
- 29 Do you provide regular medical or surgical care to professional athletes? Yes  No
- 30 Have you performed any new procedures during the past year, i.e. procedures not previously performed by you? Yes  No

**Procedures Profile...**

If Changed Since Original Application

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Please check any of the following procedures you perform or any of the agents you use. Provide any details you consider relevant in the 'notes' section. ▼

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Abdominoplasty                      | <input type="checkbox"/> Anesthesia, spinal                | <input type="checkbox"/> Atherectomy / rotation ablation               |
| <input type="checkbox"/> Abortions, therapeutic              | <input type="checkbox"/> Angiography, all others           | <input type="checkbox"/> Autologous fat Injection, penis               |
| <input type="checkbox"/> Acupuncture                         | <input type="checkbox"/> Angiography, cerebral or coronary | <input type="checkbox"/> Automated lamellar keratoplasty (ALK)         |
| <input type="checkbox"/> Amniocentesis                       | <input type="checkbox"/> Angioscopy                        | <input type="checkbox"/> Balloon valvuloplasty                         |
| <input type="checkbox"/> Anal Fissurectomy                   | <input type="checkbox"/> Appendectomy                      | <input type="checkbox"/> Bariatric surgery                             |
| <input type="checkbox"/> Anesthesia, general                 | <input type="checkbox"/> Arterial and venous lines         | <input type="checkbox"/> Biopsy, breast                                |
| <input type="checkbox"/> Anesthesia, IV analgesia (surgical) | <input type="checkbox"/> Arterial bypass                   | <input type="checkbox"/> Biopsy, cervical                              |
| <input type="checkbox"/> Anesthesia, local                   | <input type="checkbox"/> Arthroscopy                       | <input type="checkbox"/> Biopsy, heart                                 |
| <input type="checkbox"/> Biopsy, liver                       | <input type="checkbox"/> Circumcision, pediatric           | <input type="checkbox"/> Endoscopy, sigmoidoscopy, flex to 65cm        |
| <input type="checkbox"/> Biopsy, other                       | <input type="checkbox"/> CO2 laser                         | <input type="checkbox"/> Endoscopy, sigmoidoscopy, rigid               |
| <input type="checkbox"/> Blepharoplasty, cosmetic            | <input type="checkbox"/> Cobalt therapy                    | <input type="checkbox"/> ENT surgery                                   |
| <input type="checkbox"/> Blepharoplasty, functional          | <input type="checkbox"/> Collagen Injections               | <input type="checkbox"/> Enucleation                                   |
| <input type="checkbox"/> Blocks, non-spine                   | <input type="checkbox"/> Colporrhaphy and perineoplasty    | <input type="checkbox"/> Episiotomy                                    |
| <input type="checkbox"/> Blocks, spine                       | <input type="checkbox"/> Conization (hot and cold knife)   | <input type="checkbox"/> Esophageal dilation                           |
| <input type="checkbox"/> Blood banking                       | <input type="checkbox"/> Conization of cervix              | <input type="checkbox"/> Excision of breast tumor                      |
| <input type="checkbox"/> Bone grafts                         | <input type="checkbox"/> Corneal transplant                | <input type="checkbox"/> Facet injections                              |
| <input type="checkbox"/> Botox Injections, cosmetic          | <input type="checkbox"/> Coronary stent placement          | <input type="checkbox"/> Facial Lifts                                  |
| <input type="checkbox"/> Botox injections, other             | <input type="checkbox"/> Cosmetic plastic surgery          | <input type="checkbox"/> Fallopian tube removal                        |
| <input type="checkbox"/> Botox injections, pain management   | <input type="checkbox"/> Cricothyrotomy                    | <input type="checkbox"/> Fine needle aspiration                        |
| <input type="checkbox"/> Breast augmentation, cosmetic       | <input type="checkbox"/> Cryosurgery                       | <input type="checkbox"/> Fine needle biopsy                            |
| <input type="checkbox"/> Breast augmentation, reconstructive | <input type="checkbox"/> Cryotherapy                       | <input type="checkbox"/> Fistula repair                                |
| <input type="checkbox"/> Calf implants                       | <input type="checkbox"/> Culdocentesis                     | <input type="checkbox"/> Forehead lifts                                |
| <input type="checkbox"/> Capsulorrhaphy                      | <input type="checkbox"/> Dacryocystotomy                   | <input type="checkbox"/> Foreign body removal                          |
| <input type="checkbox"/> Capsulotomy                         | <input type="checkbox"/> Defibrillation                    | <input type="checkbox"/> Fracture reduction, closed, other than simple |

## Procedures Profile

continued...

If Changed Since  
Original  
Application

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Cardiac catheterization, left heart        | <input type="checkbox"/> Dermabrasion                            | <input type="checkbox"/> Fracture reduction, closed, simple         |
| <input type="checkbox"/> Cardiac catheterization, right (swan ganz) | <input type="checkbox"/> Dilation and curettage                  | <input type="checkbox"/> Fracture reduction, open                   |
| <input type="checkbox"/> Cardioversions                             | <input type="checkbox"/> Dilation and evacuation                 | <input type="checkbox"/> Free fat breast injection                  |
| <input type="checkbox"/> Carpal tunnel surgery                      | <input type="checkbox"/> Echocardiography                        | <input type="checkbox"/> Frenotomy                                  |
| <input type="checkbox"/> Cataract surgery                           | <input type="checkbox"/> Ectopic pregnancy                       | <input type="checkbox"/> Gastric lavage                             |
| <input type="checkbox"/> Cervical diskectomy                        | <input type="checkbox"/> Electroconvulsive therapy (ECT)         | <input type="checkbox"/> Gastric or ileal bypass for obesity        |
| <input type="checkbox"/> Cervical laminectomy                       | <input type="checkbox"/> Electromyography                        | <input type="checkbox"/> Gastric sleeve or bubble for obesity       |
| <input type="checkbox"/> Chalazion excision from eyelids            | <input type="checkbox"/> Endometrial biopsy                      | <input type="checkbox"/> Glaucoma procedures                        |
| <input type="checkbox"/> Cheiloplasty                               | <input type="checkbox"/> Endoscopy, bronchoscopy                 | <input type="checkbox"/> Glycolic peels                             |
| <input type="checkbox"/> Chelation therapy                          | <input type="checkbox"/> Endoscopy, colonoscopy                  | <input type="checkbox"/> Hair transplant                            |
| <input type="checkbox"/> Chemical face peel                         | <input type="checkbox"/> Endoscopy, esophagoscopy                | <input type="checkbox"/> Hand surgery                               |
| <input type="checkbox"/> Cholecystectomy                            | <input type="checkbox"/> Endoscopy, gastroscopy                  | <input type="checkbox"/> Heart biopsy                               |
| <input type="checkbox"/> Chorionic gonadotropin for obesity         | <input type="checkbox"/> Endoscopy, other                        | <input type="checkbox"/> Hemorrhoidectomy, ligation only            |
| <input type="checkbox"/> Chymopapain disc Injection                 | <input type="checkbox"/> Endoscopy, pelviscopy                   | <input type="checkbox"/> Hemorrhoidectomy, other than ligation      |
| <input type="checkbox"/> Circumcision, adult                        | <input type="checkbox"/> Endoscopy, sigmoidoscopy, flex above 65 | <input type="checkbox"/> Herniorrhaphy                              |
| <input type="checkbox"/> Histories and physicals                    | <input type="checkbox"/> Liposuction surgery                     | <input type="checkbox"/> Otoplasty                                  |
| <input type="checkbox"/> Home services                              | <input type="checkbox"/> Lumbar laminectomy                      | <input type="checkbox"/> Pacemakers (temporary/permanent)           |
| <input type="checkbox"/> Human growth hormone                       | <input type="checkbox"/> Lumbar puncture                         | <input type="checkbox"/> Pain control / management, medication only |
| <input type="checkbox"/> Hydrocelectomy                             | <input type="checkbox"/> Lumpectomy, other                       | <input type="checkbox"/> Pap smears                                 |
| <input type="checkbox"/> Hymenectomy                                | <input type="checkbox"/> Lumpectomy, superficial skin lesion     | <input type="checkbox"/> Paracentesis                               |
| <input type="checkbox"/> Hymenotomy                                 | <input type="checkbox"/> Lymph gland biopsy                      | <input type="checkbox"/> Parotidectomy                              |
| <input type="checkbox"/> Hypnosis                                   | <input type="checkbox"/> Lymphangiography                        | <input type="checkbox"/> Pelvic examination                         |
| <input type="checkbox"/> Hypophysectomy                             | <input type="checkbox"/> Manipulation under anesthesia           | <input type="checkbox"/> Penile implants                            |
| <input type="checkbox"/> Hysterectomy, abdominal                    | <input type="checkbox"/> Mentoplasty                             | <input type="checkbox"/> Percutaneous endoscopic Gastrostomy        |
| <input type="checkbox"/> Hysterectomy, vaginal                      | <input type="checkbox"/> Microsurgery                            | <input type="checkbox"/> Pericardiocentesis                         |
| <input type="checkbox"/> In vitro fertilization (IVF)               | <input type="checkbox"/> Mohs' chemosurgery                      | <input type="checkbox"/> Perineal repair                            |
| <input type="checkbox"/> Incision and drainage                      | <input type="checkbox"/> Myelogram / myelography                 | <input type="checkbox"/> Perineorrhaphy                             |
| <input type="checkbox"/> Independent medical evaluations            | <input type="checkbox"/> Myofascial trigger point injections     | <input type="checkbox"/> Peripheral nerve blocks                    |
| <input type="checkbox"/> Insertion and removal of IUD               | <input type="checkbox"/> Myringotomy                             | <input type="checkbox"/> Permanent lash liner                       |
| <input type="checkbox"/> Intrabulbar masses                         | <input type="checkbox"/> Nasal polypectomy                       | <input type="checkbox"/> Phlebography                               |
| <input type="checkbox"/> Intraocular lens implants                  | <input type="checkbox"/> Nasopharyngeal surgery                  | <input type="checkbox"/> Photorefractive keratotomy (PRK)           |

## Procedures Profile

continued...

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Intubation                                 | <input type="checkbox"/> Needle aspiration                                   | <input type="checkbox"/> Phototherapeutic keratotomy (PTK)      |
| <input type="checkbox"/> Iridectomy                                 | <input type="checkbox"/> Neonatal intensive care                             | <input type="checkbox"/> Physical therapy                       |
| <input type="checkbox"/> Joint Injection and intra-articular blocks | <input type="checkbox"/> Nerve repairs                                       | <input type="checkbox"/> Pleural biopsy, closed                 |
| <input type="checkbox"/> Joint replacement                          | <input type="checkbox"/> Nerve root injections                               | <input type="checkbox"/> Pleural biopsy, open                   |
| <input type="checkbox"/> Laceration repair                          | <input type="checkbox"/> Non-FDA approved experiments or studies             | <input type="checkbox"/> Polypectomy by endoscopy               |
| <input type="checkbox"/> Laetril use (amugdalin or vitamin B17)     | <input type="checkbox"/> Obstetrical procedures, birthing center             | <input type="checkbox"/> Prenatal care, first trimester         |
| <input type="checkbox"/> Laparoscopy                                | <input type="checkbox"/> Obstetrical procedures, home or other               | <input type="checkbox"/> Prenatal care, second trimester        |
| <input type="checkbox"/> Laryngography / laryngoscopy               | <input type="checkbox"/> Obstetrical procedures, hospital                    | <input type="checkbox"/> Prenatal care, third trimester         |
| <input type="checkbox"/> Laser hair removal                         | <input type="checkbox"/> Obstetrics, deliveries, high risk                   | <input type="checkbox"/> Prenatal exam, diagnose and refer only |
| <input type="checkbox"/> Laser skin resurfacing, face only          | <input type="checkbox"/> Obstetrics, deliveries, routine                     | <input type="checkbox"/> Prolotherapy                           |
| <input type="checkbox"/> Laser skin resurfacing, other than face    | <input type="checkbox"/> Office gynecology                                   | <input type="checkbox"/> Pterygium excision                     |
| <input type="checkbox"/> Laser surgery                              | <input type="checkbox"/> Oophorectomy  | <input type="checkbox"/> Punch biopsy                           |
| <input type="checkbox"/> LASIK                                      | <input type="checkbox"/> Orbital bone fracture repairs                       | <input type="checkbox"/> Radial keratotomy                      |
| <input type="checkbox"/> Leeps / leetz procedure                    | <input type="checkbox"/> Orchidectomy  | <input type="checkbox"/> Radiation therapy                      |
| <input type="checkbox"/> Lid repair                                 | <input type="checkbox"/> Osteopuncture                                       | <input type="checkbox"/> Radical neck dissection                |
| <input type="checkbox"/> Radioactive implants                       | <input type="checkbox"/> Sodium amytal therapy                               | <input type="checkbox"/> Tracheostomy                           |
| <input type="checkbox"/> Rapid detoxification                       | <input type="checkbox"/> Sperm banking other than temporary for own patients | <input type="checkbox"/> Trigger point injections               |
| <input type="checkbox"/> Rectocele                                  | <input type="checkbox"/> Sphincterectomy                                     | <input type="checkbox"/> Tubal ligation                         |
| <input type="checkbox"/> Retinal detachment repair                  | <input type="checkbox"/> Spinal blocks                                       | <input type="checkbox"/> Tympanostomy                           |
| <input type="checkbox"/> Retrobulbar blocks                         | <input type="checkbox"/> Spinal fusion                                       | <input type="checkbox"/> Ultrasound, obstetrical                |
| <input type="checkbox"/> Rhinoplasty, cosmetic                      | <input type="checkbox"/> Spinal infusion pump implantation                   | <input type="checkbox"/> Ultrasound, other                      |
| <input type="checkbox"/> Rhinoplasty, functional only               | <input type="checkbox"/> Spinal surgery                                      | <input type="checkbox"/> Uterine suspension                     |
| <input type="checkbox"/> Rhytidectomy                               | <input type="checkbox"/> Stereoscopy   | <input type="checkbox"/> Valvuloplasty                          |
| <input type="checkbox"/> Sacroiliac joint blocks                    | <input type="checkbox"/> Sympathectomy                                       | <input type="checkbox"/> Vasectomy                              |
| <input type="checkbox"/> Salivary gland surgery                     | <input type="checkbox"/> Tendon repair                                       | <input type="checkbox"/> Vein stripping                         |
| <input type="checkbox"/> Salpingectomy                              | <input type="checkbox"/> Tenotomy  | <input type="checkbox"/> Venography                             |
| <input type="checkbox"/> Scalene node biopsy                        | <input type="checkbox"/> Therapeutic radiology                               | <input type="checkbox"/> Ventricular shunt                      |
| <input type="checkbox"/> Sclerotherapy                              | <input type="checkbox"/> Thyroid Surgery                                     | <input type="checkbox"/> Vertebroplasty                         |
| <input type="checkbox"/> Selective nerve root blocks                | <input type="checkbox"/> Tissue expansion                                    | <input type="checkbox"/> Weight control, diet only              |
| <input type="checkbox"/> Septorhinoplasty                           | <input type="checkbox"/> Tonsillectomy                                       | <input type="checkbox"/> Weight control, medications            |

**Procedures Profile**

*continued...*

31	<input type="checkbox"/> Sex change (transsexual) surgery	<input type="checkbox"/> Tonsilloadenoidectomy (T & A)	<input type="checkbox"/> Wound debridement
	<input type="checkbox"/> Small bowel biopsy	<input type="checkbox"/> Trabeculectomy	

**Professional Duties**

32	Estimate the total number of hours you work per week in office and clinical practice including direct patient care, consultation, administrative activities, etc.	Hours per week
33	Do you provide medical information or advice, interpret files, prescribe medication, or sell any products or services via the internet or other telecommunications system?	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Medical Malpractice Insurance Claims History**

34	Are you aware of any circumstances which may result in a malpractice claim or suit being presented against you? <i>If "yes", explain in 'notes' section.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
35	Are you aware of any circumstances which may result in a malpractice claim or suit being presented against any of your partners, members of your professional association or corporation, or your employees? <i>If "yes", explain in 'notes' section.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>

**Potential Liability**

36	Are you aware of any patient you have treated in the past 24 months who developed any of the following conditions during or after treatment that may have been caused by medical negligence? <b>Please check all that apply. ▼</b>	
	<input type="checkbox"/> Brain injury	
	<input type="checkbox"/> Spinal cord injury and/or damage resulting in significant sensory and/or motor loss	
	<input type="checkbox"/> Serious burn injury	
	<input type="checkbox"/> Amputation of a significant portion of a limb(s)	
	<input type="checkbox"/> Birth trauma	
	<input type="checkbox"/> Paraplegia, quadriplegia, tetraplegia or other bodily paralysis	

*Please use the 'notes' section to explain any "Yes" responses for questions 36-39*

37	Are you aware of any patient you have treated in the past 36 months whose condition or treatment resulted in death that may have been caused by medical negligence?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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38	Are you aware of any patient you have not treated, but with whom you had a part in their care in the past 24 months by way of consultation, tests, reports, or other medical services who developed any of the following conditions during or after such medical care that may have been caused by medical negligence? <b>Please check all that apply. ▼</b>	
	<input type="checkbox"/> Brain injury	
	<input type="checkbox"/> Spinal cord injury and/or damage resulting in significant sensory and/or motor loss	
	<input type="checkbox"/> Serious burn injury	
	<input type="checkbox"/> Amputation of a significant portion of a limb(s)	
	<input type="checkbox"/> Birth trauma	
	<input type="checkbox"/> Paraplegia, quadriplegia, tetraplegia or other bodily paralysis	

39	Are you aware of any patient you have not treated, but with whom you had a part in their care in the past 36 months by way of consultation, tests, reports, or other medical services whose condition or treatment resulted in death that may have been caused by medical negligence?	Yes <input type="checkbox"/> No <input type="checkbox"/>
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## Understanding, Authorization and Signature:

**Important: This Application must be signed by the Applicant.**

I understand and agree this Renewal Application and any and all exhibits and attachments thereto will be made a part of any policy issued, and any such policy will be issued in reliance upon the representations made herein which are warranted to be true and complete. I further understand that these answers and statements are material and agree that failure to provide a true and complete response to the foregoing questions or to supplement as provided above may, at the option of MoDocs, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, training, professional reputation, previous claims and suits, and fitness to engage in the activities authorized by my license to practice medicine, including, but not limited to, authorization to every person or entity, public or private, to release to MoDocs, any documents, records, or other information bearing upon the foregoing. I further authorize the use of a copy of this authorization in lieu of its original. I further authorize MoDocs to forward additional information to me by facsimile.

I understand and agree these investigations shall not be confined to information submitted in this Application, but shall include any other sources of information deemed relevant by MoDocs as may be authorized by law.

Signature \_\_\_\_\_

\_\_\_\_\_  
Signature in full of Applicant

\_\_\_\_\_  
Please PRINT Name of Signatory

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date