

## 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

WEB



### 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)	
		Maiden name	Degree (MD/DO) / other	Date of Birth / /	Age in years	Social security number
		BNDD number	DEA number	NPI		
<b>Residential Address</b>	2	Street				Apt
		City	State	Zip	County	
		Home phone ( ) -	Home email			
		Practice name				
<b>Practice Address</b>		Street				Suite
		City	State	Zip	County	
		Office phone ( ) -	Office fax ( ) -	Office email		
		Contact person	Number of practice locations			
		Send billing to: <input type="checkbox"/> Residence <input type="checkbox"/> Practice <input type="checkbox"/> Other <i>complete information below</i> ▼				
<b>Billing Address</b>		Billing name				
		Street				Suite
		City	State	Zip		
		Type of practice (Check one): <input type="checkbox"/> Private practice <input type="checkbox"/> Urgent care center <input type="checkbox"/> Other <i>specify</i> ►				
<b>Practice Profile</b> 5-13		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		
		Phone ( ) -	Fax ( ) -	Administrator's name (First, Middle, Last)		
		Partner's names			Trade name used (if any)	
<b>Employer, Partnership or Corporation Information</b>		If you need more space, use the 'notes' section.				
		▼				

**Practice Profile**

*continued...*

**Paramedical Personnel Census**

*In the blank space provided enter the number of personnel employed.*

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

12

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. ▼

- |                                                      |                                               |                                                              |
|------------------------------------------------------|-----------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Anesthesiologist Assistant♦ | <input type="checkbox"/> Nurse practitioners♦ | <input type="checkbox"/> Physicians—MD's or DO's             |
| <input type="checkbox"/> Certified nurse midwives    | <input type="checkbox"/> Nurses—LPN           | <input type="checkbox"/> Psychologists                       |
| <input type="checkbox"/> Dialysis technicians        | <input type="checkbox"/> Nurses—RN            | <input type="checkbox"/> Psychotherapists                    |
| <input type="checkbox"/> Inhalation therapists       | <input type="checkbox"/> Opticians            | <input type="checkbox"/> Registered heart/lung perfusionists |
| <input type="checkbox"/> Laboratory technicians      | <input type="checkbox"/> Optometrists         | <input type="checkbox"/> Surgical assistants                 |
| <input type="checkbox"/> Medical assistants          | <input type="checkbox"/> Other employees      | <input type="checkbox"/> X-Ray technicians                   |
| <input type="checkbox"/> Nurse anesthetists—CRNA's   | <input type="checkbox"/> Physician assistant♦ |                                                              |

**Other Business Interest**

*Check all that apply*

13

If you or your partnership or corporation own any interest in, or operate, any of the following, please check as appropriate, and provide additional information on all checked responses in the 'notes' section: ▼

- |                                                               |                                                |                                                                       |
|---------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> Abortion clinic                      | <input type="checkbox"/> Emergency center      | <input type="checkbox"/> Nursing home                                 |
| <input type="checkbox"/> Birthing center                      | <input type="checkbox"/> Hospital              | <input type="checkbox"/> Sanitarium                                   |
| <input type="checkbox"/> Blood bank                           | <input type="checkbox"/> Infirmary             | <input type="checkbox"/> Sperm bank                                   |
| <input type="checkbox"/> Clinic with bed and board facilities | <input type="checkbox"/> Laser equipment       | <input type="checkbox"/> Surgical bank                                |
| <input type="checkbox"/> Commercial laboratory                | <input type="checkbox"/> Lithotripsy equipment | <input type="checkbox"/> Weight reduction clinic                      |
| <input type="checkbox"/> Drug rehabilitation center           | <input type="checkbox"/> Medical foundation    | <input type="checkbox"/> Other medically related business enterprises |

**Professional Profile**

14-38

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

- |    |                                                                                                                                                                                                                                                                                                            |                              |                             |
|----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| 14 | Have you ever been denied board certification or recertification?                                                                                                                                                                                                                                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 15 | 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"/> |
| 16 | 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"/> |
| 17 | Have you ever been indicted or convicted of a crime other than a minor traffic violation?                                                                                                                                                                                                                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 18 | 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"/> |
| 19 | Has your membership in any professional society or association ever been refused, censured, suspended or revoked?                                                                                                                                                                                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 20 | 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"/> |
| 21 | 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"/> |
| 22 | 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"/> |
| 23 | 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"/> |
| 24 | 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"/> |
| 25 | 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"/> |
| 26 | Do you perform surgery—except for incision of boils, suturing of skin or superficial fascia?                                                                                                                                                                                                               | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

**Professional Profile**

continued...

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

- 27 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  No
- 28 Do you assist—only at surgery? If you answer "Yes", complete the following: ▼ Yes  No   
 Number of own patients per year? \_\_\_\_\_ Number of other patients per year? \_\_\_\_\_
- 29 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  No
- 30 Do you perform general anesthesia? If "Yes", check as appropriate below. ▼ Yes  No   
 Hospital                       Non-hospital facility                       Office
- 31 Do you supervise CRNA's who provide general anesthesia? Yes  No
- 32 Do you perform obstetrical procedures? Yes  No
- 33 Do you perform cesarean sections? If "Yes", check as appropriate below. ▼ Yes  No   
 Elective                       Emergency
- 34 Do you perform abortions? If "Yes", check as appropriate below. ▼ Yes  No   
 First trimester                       Second trimester                       Third trimester
- 35 Do you practice in an emergency room? If you answer "Yes", complete the following: ▼ Yes  No   
 Hours per month? \_\_\_\_\_
- 36 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
- 37 Do you provide regular medical or surgical care to professional athletes? Yes  No
- 38 Have you performed any new procedures during the past year, i.e. procedures not previously performed by you? Yes  No

**Procedures Profile**

- 39 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                         |

## Procedures Profile

continued...

- |                                                                     |                                                                  |                                                                        |
|---------------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------------------------|
| <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 |
| <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 discectomy                        | <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                                 |

## Procedures Profile

continued...

- |                                                                     |                                                                  |                                                                     |
|---------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------|
| <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)           |
| <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                    |

**Procedures Profile**  
continued...

39

- |                                                           |                                                                              |                                                      |
|-----------------------------------------------------------|------------------------------------------------------------------------------|------------------------------------------------------|
| <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 |
| <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**  
40-47

- |    |                                                                                                                                                                            |                                                          |
|----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 40 | Are you entering practice for the first time since completing an internship, residency program, fellowship, or military service?                                           | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 41 | 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                                           |
| 42 | Do you have teaching or faculty appointments? If yes, name the institution. ▼<br>Name of institution                                                                       | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 43 | If yes, are you responsible for the supervision of residents, interns or fellows?                                                                                          | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 44 | Does the institution provide you with coverage for these responsibilities?                                                                                                 | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 45 | Do you have any medical director responsibilities? If yes, name the institution. ▼<br>Name and address of institution                                                      | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|    | ▶ Does this institution provide you with insurance coverage?                                                                                                               | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|    | ▶ Or, do you have insurance coverage from any other source?                                                                                                                | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 46 | Do you treat or review treatment of prison inmates?                                                                                                                        | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 47 | 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"/> |

Other

e 10 / App R7

### Specialty

48-52

48	Primary specialty	% of Practice	Years practicing primary specialty
49	Are you board certified in your primary specialty? If yes, name the board. ▼		Yes <input type="checkbox"/> No <input type="checkbox"/>
	Name of the board		Date / /
50	Secondary specialty	% of Practice	Years practicing secondary specialty
51	Are you board certified in your secondary specialty? If yes, name the board. ▼		Yes <input type="checkbox"/> No <input type="checkbox"/>
	Name of the board		Date / /

### Memberships

Please use the 'notes' section for additional listings.

52 List all county, state, national and specialty medical society memberships. ▼

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### Licensed to Practice

53 List all states in which you are licensed to practice, primary practice state first. If temporary, submit a copy of your permit. Please check the box to the far right if you plan to practice in that state in the next year. ▼

State (primary practice)	License number	Date / /	Status <i>see below</i> ♦	% of Practice <input type="checkbox"/>
State	License number	Date / /	Status <i>see below</i> ♦	% of Practice <input type="checkbox"/>
State	License number	Date / /	Status <i>see below</i> ♦	% of Practice <input type="checkbox"/>
State	License number	Date / /	Status <i>see below</i> ♦	% of Practice <input type="checkbox"/>

♦ Status is **Temporary / Active / Inactive / Suspended / Restricted / Revoked**  
If anything other than Active, explain in notes. if more than four, list in 'notes' section.

### Practice Positions

If you need more space, use the 'notes' section.

54 List previous practice positions other than current practice position. Please explain any date gaps in practice positions. ▼

Entity name	Address / City / State / Type of practice	From / /	To / /
Entity name	Address / City / State / Type of practice	From / /	To / /
Entity name	Address / City / State / Type of practice	From / /	To / /
Entity name	Address / City / State / Type of practice	From / /	To / /
Entity name	Address / City / State / Type of practice	From / /	To / /
Entity name	Address / City / State / Type of practice	From / /	To / /

### Staff Privileges

55 List all hospitals or other facilities at which you have staff privileges, primary hospital first. Please check the box to the far right if you wish us to issue a certificate of insurance to this hospital or facility. ▼

Hospital / facility	Address / City / State	County	Category <i>see below</i> ♦	<input type="checkbox"/>
Hospital / facility	Address / City / State	County	Category <i>see below</i> ♦	<input type="checkbox"/>
Hospital / facility	Address / City / State	County	Category <i>see below</i> ♦	<input type="checkbox"/>
Hospital / facility	Address / City / State	County	Category <i>see below</i> ♦	<input type="checkbox"/>
Hospital / facility	Address / City / State	County	Category <i>see below</i> ♦	<input type="checkbox"/>

♦ Category is **Active / Courtesy / Other**

**Education**

56-57

56	Medical school graduated	City / State / Country	Graduation date / /	Degree
	Internship hospital	City / State / Country	Completion date / /	Type
	Residency hospital	City / State / Country	Completion date / /	Type
	Residency hospital	City / State / Country	Completion date / /	Type
	Fellowship location	City / State / Country	Completion date / /	Type

57 If you are a foreign medical graduate, are you certified by the Educational Council for Foreign Medical School Graduates? Yes  No

**Medical Malpractice Insurance**

58-71

58 Limit of liability requested, check one. *Limits are per medical incident / annual aggregate.* ▼  
 \$100,000 / \$300,000       \$200,000 / \$600,000       \$500,000 / \$1,000,000  
 \$1,000,000 / \$1,000,000       \$1,000,000 / \$3,000,000

59 Effective date requested ▶ / /      Is prior acts coverage requested? Yes  No

60 Will you be carrying additional professional liability insurance with another company? Yes  No   
 If "yes", please show, in the 'notes' section, the name of the company, limits of liability, effective dates, and what aspect of your practice the other insurance covers.

61 Retroactive date of current insurance ▶ / /      Retroactive date requested ▶ / /

62 Are you seeking coverage during your retroactive period for any procedures which you did not check in question number 39? *If yes, please list below all procedures for which you seek retroactive coverage that you did not check in question number 39.* ▼ Yes  No

Please use the 'notes' section for additional listings.

**Insurance History**

63 Insurance history for the preceding five (5) years, begin with current policy (Please indicate whether or not you purchased a tail, and attach a copy of your current declarations page): ▼

Company name	Policy type / Policy number / Liability limits	From / /	To / /	Tail bought Yes <input type="checkbox"/> No <input type="checkbox"/>
Company name	Policy type / Policy number / Liability limits	From / /	To / /	Tail bought Yes <input type="checkbox"/> No <input type="checkbox"/>
Company name	Policy type / Policy number / Liability limits	From / /	To / /	Tail bought Yes <input type="checkbox"/> No <input type="checkbox"/>
Company name	Policy type / Policy number / Liability limits	From / /	To / /	Tail bought Yes <input type="checkbox"/> No <input type="checkbox"/>
Company name	Policy type / Policy number / Liability limits	From / /	To / /	Tail bought Yes <input type="checkbox"/> No <input type="checkbox"/>
Company name	Policy type / Policy number / Liability limits	From / /	To / /	Tail bought Yes <input type="checkbox"/> No <input type="checkbox"/>

## Medical Malpractice Insurance

continued...

### Claims History

### Potential Liability

64	Has a medical malpractice claim or suit been presented against you, or has any amount of money been paid by you or on your behalf in a claim of medical malpractice? <i>If "yes", complete an attached 'Claim / Suit Questionnaire' for each case.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
65	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"/>
66	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"/>
67	If you have answered yes to Question 64, 65, or 66 above, are there any claims or suits or circumstances for which you answered yes that you have not reported to your current professional liability insurer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
68	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	
69	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"/>
70	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	
71	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"/>

**Please use the 'notes' section to explain in detail any "checked or Yes" responses for questions 68–71.**





## Understanding, Authorization and Signature:

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

As a licensed physician or surgeon, the undersigned has made application for insurance to Missouri Doctors Mutual Insurance Company (MoDocs), and in connection with said Application has furnished the above information and the information in the 'notes' section attached.

I understand and agree this 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 MoDocs, through the Missouri Highway Patrol or any other agency, to conduct a criminal history file check or investigation by name and identifiers to determine the existence of any arrest resulting in conviction and furnish a response to MoDocs.

I authorize MoDocs, or any third party, to obtain and/or run a personal credit report on myself and a business credit report on my medical practice/clinic.

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

## Hospital Records Authorization and Signature:

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

As a licensed physician or surgeon, the undersigned has made application for insurance to Missouri Doctors Mutual Insurance Company (MoDocs) and in connection with said application has furnished this authorization for release of information.

I authorize any hospital at which I currently have privileges, or any hospital at which I have in the past had privileges, to release any and all records relating to my service at such hospital including, but not limited to, complaints of any nature, and the contents of my medical staff or peer review files.

I further authorize the use of a copy of this authorization in lieu of its original.

Signature \_\_\_\_\_

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

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

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

