

# Missouri Doctors Mutual Insurance Company (NAIC #11964)

## Locum Tenens Application

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



### Before you begin

- ϕ 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.
- ϕ An attached curriculum vitae will not suffice; this application must be completed.
- ϕ This completed application, together with any supplementary information, must be personally reviewed, signed and dated in ink by the applicant.

### Locum Tenens Coverage For

1	Practice name	Policy number
	Physician(s) name	
	Physician(s) name	
	Street	Suite
	City	State Zip County
	Office phone ( ) -	Contact person

### Personal

2	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	

### Residential Address

3	Street	Apt
	City	State Zip County
	Home phone ( ) -	Home email Business phone ( ) -

### Professional Profile

4-9

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

4	Have you ever been denied board certification or recertification?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5	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"/>
6	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"/>
7	Have you ever been indicted or convicted of a crime other than a minor traffic violation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
8	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"/>
9	Has your membership in any professional society or association ever been refused, censured, suspended or revoked?	Yes <input type="checkbox"/> No <input type="checkbox"/>



**Procedures Profile**

27 In your locum tenens capacity, please list any procedures you will be performing that are different from those presently performed by the physician you are replacing ▼  
 (Please respond carefully and completely, as coverage may not apply for types of procedures that are different from those presently performed by the physician you are replacing)

---



---

**Specialty**

28-32

28 Primary specialty | % of Practice | Years practicing primary specialty

---

29 Are you board certified in your primary specialty? If yes, name the board. ▼ Yes  No

29 Name of the board | Date / /

---

30 Secondary specialty | % of Practice | Years practicing secondary specialty

---

31 Are you board certified in your secondary specialty? If yes, name the board. ▼ Yes  No

31 Name of the board | Date / /

**Licensed to Practice**

32 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 see below ♦	% of Practice <input type="checkbox"/>
State	License number	Date / /	Status see below ♦	% of Practice <input type="checkbox"/>
State	License number	Date / /	Status see below ♦	% of Practice <input type="checkbox"/>
State	License number	Date / /	Status see below ♦	% 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.

**Education**

33-35

33 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

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

**Insurance History**

35 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**

36-41

Claims History

36 Are you now, or have you ever been involved, directly or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services? ▼ Yes  No

37 If "Yes", how many? \_\_\_\_\_

38 If "Yes", have these been reported to your insurer? Yes  No

39 Do you have knowledge of any claims, potential claims, or suits in which you may become involved, including without limitation, knowledge of any alleged injury arising out of the rendering or failing to render professional services which may give rise to a claim? Yes  No

If "Yes", have these been reported to your insurer? Yes  No

40 If you have answered "yes" to Question 36, 37, 38 or 39 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  No

41 If you have answered "yes" to Question 36, 37, 38, 39 or 40 above, have you completed the attached claims form? Yes  No

Potential Liability

*Please use the 'notes' section to explain in detail any "checked or Yes" responses for questions 42-45*

42 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? **Please check all that apply.** ▼

- Brain injury
- Spinal cord injury and/or damage resulting in significant sensory and/or motor loss
- Serious burn injury
- Amputation of a significant portion of a limb(s)
- Birth trauma
- Paraplegia, quadriplegia, tetraplegia or other bodily paralysis

43 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  No

44 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? **Please check all that apply.** ▼

- Brain injury
- Spinal cord injury and/or damage resulting in significant sensory and/or motor loss
- Serious burn injury
- Amputation of a significant portion of a limb(s)
- Birth trauma
- Paraplegia, quadriplegia, tetraplegia or other bodily paralysis

45 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  No



## 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 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

