



**MEDICAL DIRECTOR PROFESSIONAL LIABILITY APPLICATION**

1. Name of Applicant: \_\_\_\_\_

2. Mailing Address: \_\_\_\_\_

3. Location Address: \_\_\_\_\_

(If multiple name and locations, please attach list)

4. Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

5. a) Desired Effective Date: \_\_\_\_\_

b) Desired Limits of Liability: \$ \_\_\_\_\_ / \$ \_\_\_\_\_

c) Desired Deductible: \$ \_\_\_\_\_

6. Name of Organization where applicant provides services as Medical Director: \_\_\_\_\_

7. Type of Organization: \_\_\_\_\_

8. Number of Hours per week will be providing Medical Director services: \_\_\_\_\_

9. Number of years as Medical Director: \_\_\_\_\_

**Please attach a copy of contract between Medical Director & organization describing the duties & responsibilities of the Medical Director and a copy of the Medical Director's resume showing training & experience.**

10. Exposure Information for Organization:

Number of Beds: \_\_\_\_\_ Number of Outpatient Visits: \_\_\_\_\_ Number of Ambulances: \_\_\_\_\_

11. Does the applicant also have or could they be called upon to act within their capacity as a physician to treat, intervene in the treatment, direct the treatment or consult in the treatment of any patient/client?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide details including how often such circumstances occur: \_\_\_\_\_

If yes, please provide details of medical malpractice insurance & attach proof of coverage: \_\_\_\_\_



12. ATTACH DETAILED EXPLANATION FOR ANY ""YES"" ANSWERS:

Has the applicant:	YES	NO
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?	_____	_____
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	_____	_____
c) Ever been treated for alcoholism or drug addiction?	_____	_____
d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?	_____	_____

13. Has any medical malpractice claim or suit ever been made against you ?

Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, please attach details.

14. Has any claim or suit ever been made against you with regards to services provided as Medical Director?

Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, please attach details.

15. Is the applicant aware of any circumstances which may result in any claim or suit?

Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, please give full details.

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

**FOR KENTUCKY RISKS:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Name of Applicant: \_\_\_\_\_  
Please Print Title

Signature: \_\_\_\_\_  
Name Date

(NOTE: Application must be signed by the owner or president or principal)