



PROFESSIONAL LIABILITY APPLICATION MEDICAL DIRECTOR (Edition 06.2026)

Please submit a fully executed contract between the Medical Director and the Organization that outlines the Medical Director's duties and responsibilities, as well as a copy of the Medical Director's résumé indicating relevant training and experience.

Section 1: Applicant Information

1. Applicant Name: _____
2. Mailing Address: _____
3. Telephone Number: _____ Website Address: _____

Section 2: Coverage Requested

4. Effective Date: _____
5. Liability Limits: \$ _____ / \$ _____
6. Deductible: \$ _____

Section 3: Services Provided

7. Name of Organization for which the applicant serves as Medical Director: _____
8. Organization Location Address: _____
(For multiple names and locations, please provide an attached list)
9. Type of Organization: _____
10. Does the organization(s) above maintain separate professional liability coverage with limits equal to or greater than those specified in Section 2 of this application? ☐ Yes ☐ No
11. Number of hours per week the applicant will provide Medical Director services: _____
12. Years of experience as Medical Director: _____
13. Please provide exposure information for the Organization where the Medical Director will provide services, including the following: (If none, state none)
 - a) Number of Beds: _____
 - b) Number of Outpatient Visits: _____
 - c) Number of Ambulances: _____
14. Is coverage requested for the Medical Director's administrative duties? ☐ Yes ☐ No
15. Is coverage requested for the Medical Director's supervisory duties? ☐ Yes ☐ No
16. Does the applicant have any responsibility, or potential responsibility, to treat, direct, intervene in, or consult on medical treatment for any individual or client in their role as a physician? ☐ Yes ☐ No
 - a) If Yes, please provide a detailed explanation, including the nature of the services provided, the types of individuals or clients treated, and the extent of the applicant's involvement:

 - b) If Yes, please provide details of the applicant's medical malpractice insurance and attach proof of coverage:



17. Is the applicant accredited, certified, licensed, or a member of any professional association or governing body? ☐ Yes ☐ No

If Yes, describe: _____

Section 4: Disclosure of Disciplinary, Claims, and Incidents

18. Disclosure of Disciplinary or Legal History:

Attach a detailed explanation for any **YES** answers below:

Has the applicant or have any of the employees:

a) Ever been subject to disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association? ☐ Yes ☐ No

b) Ever been convicted of any act committed in violation of any law or ordinance (other than traffic offenses)? ☐ Yes ☐ No

c) Ever been treated for alcoholism or drug addiction? ☐ Yes ☐ No

d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused, accepted only on special terms, or voluntarily surrendered? ☐ Yes ☐ No

19. Within the past five (5) years, has any medical malpractice claim or lawsuit been made against the insured? ☐ Yes ☐ No

If Yes, please attach full details, including dates, allegations, and disposition.

20. Within the past five (5) years, has any claim or lawsuit been made against the insured arising out of services provided in the role of Medical Director? ☐ Yes ☐ No

If Yes, please attach full details.

21. Is the applicant aware of any facts, circumstances, acts, errors, or omissions that may reasonably be expected to give rise to a claim against the insured that would be covered under this policy? ☐ Yes ☐ No

If Yes, please provide full details: _____

Signature and Attestation

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.

ELECTRONIC SIGNATURE: If the application is e-signed, it must be accompanied by the verification page or proof that it was securely e-signed along with the date, time stamp, and originating email address.

Name of Applicant: _____

Please Print

Title

Signature: _____

Name

Date

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

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