GREAT AMERICAN INSURANCE GROUP | Specialty Human Services

Individual Medical Professional Questionnaire

Instructions: An application must be completed for each medical doctor or nurse practitioner to be named on the policy. Please complete the entire form and attach curriculum vitae. If a section does not apply or is not relevant, answer "N/A" or "none". Information provided by you will be used by underwriters in determining the acceptability of adding the specific medical doctor or nurse practitioner to the professional insurance coverage.

		Yes	No
1.	Your name _____		
2.	Agency/organization name _____		
3.	Medical specialty _____ Are you board certified?	☐	☐
4.	License number/state _____		
5.	Is the coverage requested to be a Primary or Excess basis? **(If excess is requested, minimum underlying limits of $1 million per claim must be verified and a copy of the physicians primary declaration page must be attached)**		
6.	List all accreditations _____		
7.	Is your organization a nonprofit? _____		
8.	What is your working relationship with the clinic/center/organization? ☐ Employee ☐ Contractor ☐ Volunteer		
9.	How many hours per week you work on behalf of the organization? _____ How many weeks per year? _____		
10.	List the responsibilities/duties you perform for the organization (please be specific). _____ _____ _____		
11.	Do you, or will you, perform any of the following medical procedures or services on behalf of the organization? **If yes,** how many per year? _____	☐	☐

	Times/Yr.	None
Entry Level Physicals		☐
Methadone Treatment		☐
Infant/Child Medical Care		☐
Medical Detox		☐
HIV/AIDS Treatment		☐
Prescribing Medications		☐

12.	Do you provide any other medical procedures or service on behalf of the organization? **If yes,** please describe below: _____ _____ _____	☐	☐
13.	Do you obtain consent to treat patients?	☐	☐
14.	If the patient requires more specialized care, do you refer the patient to a specialist? **If yes**, how do you determine the specialist that you refer the patient to? _____	☐	☐
15.	Do you admit patients to the hospital?	☐	☐
16.	Do you discharge patients from the hospital?	☐	☐

Continued	Yes	No
17. Have you ever had a malpractice claim or suit filed against you? **If yes**, please attach detailed claim information, and a detailed description for each claim or allegation.	☐	☐
18. Have all known potential claims, incidents or suits, if any, been reported to your present carrier?	☐	☐
19. Have you ever had your medical license revoked, suspended, restricted, or placed on probation?	☐	☐
20. Has your license to practice medicine or medical staff privileges or appointment to a hospital ever been suspended, voluntarily withdrawn, reduced, withheld, denied, revoked or subjected to any disciplinary action? **If yes**, describe circumstances _____	☐	☐
21. Have you ever been the subject of an investigation, disciplinary proceeding or reprimand?	☐	☐
22. Have you ever been convicted of a crime or felony?	☐	☐
23. Have you ever been treated for alcoholism or drug addiction?	☐	☐
24. Provide information on your in-force malpractice. **If none exists**, please indicate **"none"** a. Insurance company name _____ Expiration date _____ b. Limits of liability $_____ Policy # _____ c. Does your malpractice policy cover you while performing work for the agency/organization?	☐	☐

Licensed professional signature _____ **Date completed** _____

WARRANTY, AUTHORIZED SIGNATURE AND CONTINUING DUTY TO UPDATE

The undersigned is an authorized representative of the prospective named insured, and acknowledges that the information provided with the application, including all questionnaires, supplements, attachments and replies to underwriter inquiries and applications form other insurance companies that have been submitted to Great American and made part of this application:

1. **Will be relied upon by Great American Insurance Group insurers in determining the acceptability of the prospective named insured and the premium amount to be charged;**
2. **Are true, accurate and complete; and**
3. **Will be considered an integral part of any resultant insurance contract.**

The undersigned further agrees that the prospective named insured has a continuing duty, through the date of policy inception, to update this application, including all questionnaires, supplements, and replies to underwriter inquiries.

Signature and printed name and title of authorized representative of applicant an date signed:

Signed _____ **Name** _____

Title _____ **Date** _____