PHYSICIANS REIMBURSEMENT FUND, INC.
A Risk Retention Group

APPLICATION – MD Locum Tenens

Applicant Information:

1. Name:____

   CA Med. Lic. #________________________ Expiration Date:______________________

2. Contact information:

   a) Primary office address:____________________________________

   ____

   b) Primary office telephone:____________________________________

   c) Office facsimile number:____________________________________

   d) Pager number:____________________________________

   e) Mobile telephone:____________________________________

   f) E-mail address:____________________________________

   g) Home address:____________________________________

   ____

   h) Home telephone:____________________________________

3. Medical specialty:____________________________________

4. Subspecialty (if applicable):____________________________________

5. Has your specialty or type of practice changed in the last 3 years?

   ☐ Yes ☐ No

   If "Yes," please explain: ____________________________________

   ____

6. Date of Birth:______________________________ SS#________________________

7. Medical School:________________________ Date completed:________________________

8. Internship______________________________ Date completed:_________________________

9. Residency:_____________________________ Date completed:_________________________

10. Specialty Society Memberships:____

____

11. Hospital Staff Affiliations:____

____

12. Teaching Appointments____

13. Have you ever received any claim, demand for compensation, notice of intent to sue, summons or demand for arbitration arising from professional services rendered?

☐ Yes ☐ No

If "Yes," please provide the following information for each such claim:

a) Date of Incident:____

b) Nature of Claim:____

c) Date Resolved:____

d) Nature of Resolution (including amount of any settlement or judgment or award):

____

Use a separate page if necessary.

14. Names and dates of coverage of any previous professional liability insurers. (An authorization to obtain your liability history from prior insurers is attached.)

Name of Insurer	*Dates of Coverage*

15. Has your professional liability coverage ever been cancelled or not renewed?

☐ Yes ☐ No

If "Yes," please provide the name of the insurer and the reasons given (if any) for the cancellation or non-renewal:

____

16. Identify any special procedures you perform or participate in which could be regarded as innovative, experimental or for which long-term follow-up has not been established:

____

____

17. If you are American Board Certified, please provide your date of certification:

____

18. If you are not American Board Certified:

a) Have you ever been denied Board Certification after taking the examination for certification?

☐ Yes ☐ No

b) Are you American Board eligible in your specialty?

☐ Yes ☐ No

Expiration date: ______________________________

c) Do you plan to take your American Board Certification Examinations?

☐ Yes ☐ No

Planned date: ______________________________

19. Has your license to practice your profession in any jurisdiction or your Drug Enforcement Agency or other controlled substances authorization ever been limited, suspended, revoked, denied or subjected to probationary conditions, or have proceedings toward any of those ends been instituted?

☐ Yes ☐ No

20. Have you ever voluntarily relinquished any medical staff membership, clinical privileges, professional license(s) or narcotics registration under threat of disciplinary action?

☐ Yes ☐ No

21. Have you ever been denied membership on any hospital medical staff, or advancement in medical staff status, or has such a denial been recommended by a standing medical staff committee or governing board?

☐ Yes ☐ No

22. Has your medical staff membership or medical staff status or your clinical privilege(s) at any hospital ever been limited, suspended, revoked, not renewed or subject to probationary conditions, or have proceedings toward any of those ends been instituted or recommended by a standing medical staff committee or governing board?

☐ Yes ☐ No

23. Has your request for any specific clinical privileges ever been denied or granted with stated limitations (aside from ordinary and initial requirements of proctorship) or has such a denial or limitation been recommended by a standing medical staff committee or governing board?

☐ Yes ☐ No

24. Do you have any mental or physical health problems that may affect your ability to practice or the quality of your practice?

☐ Yes ☐ No

25. Have you ever been denied certification, or has your eligibility status changed with respect to certification, by a specialty board?

☐ Yes ☐ No

26. Has any investigation, review or audit by a provider organization (IPA, MSO or HMO) or other credentialing agency ever resulted in penalties, restrictions, or modification of your privileges or provider status?

☐ Yes ☐ No

27. Have you ever been convicted of a felony or have any felony charges been filed against you?

☐ Yes ☐ No

If the answer to any of questions 19 through 27 is "Yes," or if you wish to provide any other pertinent information, please include full details on a separate page.

I certify that the information contained in this application is complete and correct to the best of my knowledge, and I understand that PRF will be relying upon this information in reaching its decision whether to extend insurance coverage to me.

Name: ______________________________________
(Please print)

Signature:____________________________________

Date: _______________________________________

LOCUM TENENS FOR: ____
NAME OF PRF INSURED / POLICY NUMBER

DATES OF COVERAGE: ____

Please return the completed application (including attachments) together with the following:

- A copy of Applicant's most current curriculum vitae.
- A check for $100 made out to the PRF (non-refundable application fee).
- Dates of coverage requested.

Mail or deliver to:

Physicians Reimbursement Fund Inc., A Risk Retention Group
711 Van Ness Avenue, Suite 430
San Francisco, CA 94102
415/921-0498 (Telephone) 415/921-7862 (Facsimile)

NOTICE:
This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

AUTHORIZATION FOR THE RELEASE OF INSURANCE INFORMATION

The undersigned hereby authorizes and requests the release by each and any of his/her former or present professional liability insurance providers of any and all information, whether confidential or otherwise, requested by the Physicians Reimbursement Fund, Inc., A Risk Retention Group or its representatives.

For purposes of the above, a copy of this authorization shall be sufficient accompanying any request for information. This Authorization shall be effective for six months from the date executed.

Date: ____

Signature:____

Name: ____
(Please print)

Address: ____