

PHYSICIANS REIMBURSEMENT FUND, INC.
A Risk Retention Group

APPLICATION FOR INSURANCE
Physician Extender Locum Tenens

Applicant Information:

1. Name: _____

CA Med. Lic. # _____ Expiration Date: _____

2. Physician Extender specialty (please check one):

Nurse Practitioner Internal Medicine/GYN only/Family Practice

Nurse Practitioner Pediatrics

Nurse Practitioner Obstetrical

Nurse Midwife

Physician Assistant

Other: _____

3. a) Name of practice or practice group: _____

b) Name of practice manager: _____

4. 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: _____

5. Has your specialty changed in the last 3 years?

Yes No

If “Yes,” please explain: _____

6. Date of Birth: _____ SS# _____

7. Professional School: _____

Date completed: _____

8. Degree, Diploma or Certificate awarded: _____

9. Are you certified by any medical group or association (e.g., American College of Nurse-Midwives)?

Yes No Not Applicable

If “No,” please explain: _____

10. Are you a current member in good standing of any medical group or association (e.g., American College of Nurse-Midwives)?

Yes No Not Applicable

If “Yes,” please identify group or association: _____

If “No,” please explain: _____

11. Do you intend to work more than 3 hours per week at any office or clinic (practice location) other than the primary office identified above?

Yes No

If “Yes,” please provide the following information for each additional practice location:

a) Office address: _____

b) Office telephone: _____

c) Office facsimile number: _____

12. 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.

13. 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

14. 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:

15. Has your license to practice your profession in any jurisdiction ever been limited, suspended, revoked, denied or subjected to probationary conditions, or have proceedings toward any of those ends been instituted?

Yes No

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

Yes No

17. Have you ever been denied certification, or has your eligibility status changed with respect to certification in your specialty?

Yes No

18. 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 15 through 18 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: _____