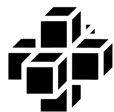

PHYSICIANS REIMBURSEMENT FUND, INC.
A Risk Retention Group

APPLICATION – MD & DO Locum Tenens

Applicant Information:

1. First Name: ________________ Middle Initial: ______ Last Name: ______________________

   Date of Birth: __________________ Social Security #: _______________________________

   CA Medical License #: ___________________ Expiration Date: ______________________

   DEA #: _______________________________ Expiration Date: ______________________

   ➢ *Attach a copy of your current professional license and DEA certificate.*

2. Personal Contact Information:

   a) Cell phone: ____

   b) Email address: ____

   c) Home address: ____

   d) Home phone: ____

3. Current type of practice: ☐ Solo ☐ Partnership ☐ Corporation ☐ Other

4. Current Practice Information:

   a) Practice Name: ____

   b) Primary address: ____

      ____

   c) Primary phone: ____

   e) Fax number: ____

   ➢ *Use a separate page to add any additional practice locations.*

5. Current Practice Manager:

   b) Name: ____

   c) Phone: ____

   d) Email: ____

6. Medical specialty: ____

7. Subspecialty (if applicable): ____

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

☐ Yes ☐ No

If Yes, please explain: ______________________________

____

9. Medical School:______________ Date completed:______________

10. Internship:______________ Date completed:______________

11. Residency:______________ Date completed:______________

12. Fellowship:______________ Date completed:______________

13. Specialty Society Memberships:______________________________

14. Hospital Staff Affiliations:______________________________

15. Teaching Appointments______________________________

16. Have you 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 <u>each</u> 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 for any additional claims.*

17. Provide the names and dates of coverage for all previous professional liability providers. Also, obtain your claims history for the past ten years from these providers.

<u>Name of Provider</u> <u>Dates of Coverage</u>

____

____

____

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

☐ Yes ☐ No

If Yes, provide the name of the provider and the reasons given for the cancellation or non-renewal:

19. List 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:

____

20. If you are American Board of Medical Specialties (ABMS), provide your certification and expiration dates:
Certification date: ____________________ Expiration date: __________________________

21. If you are not ABMS Certified, answer the following:

a) Have you been denied ABMS Certification after taking the certification examination?

☐ Yes ☐ No

b) Are you ABMS eligible in your specialty?

☐ Yes ☐ No

Expiration date: ____

c) Do you plan to take your ABMS certification examination?

☐ Yes ☐ No

Planned date: ____

22. Has your license to practice medicine in any jurisdiction or your DEA or other controlled substances authorization been limited, suspended, revoked, denied or subjected to probationary conditions, or have proceedings toward any of those ends been instituted?

☐ Yes ☐ No

23. Have you voluntarily relinquished any medical staff membership, clinical privileges, professional licenses or narcotics registrations under threat of disciplinary action?

☐ Yes ☐ No

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

☐ Yes ☐ No

25. Has your medical staff membership status or your clinical privilege(s) at any hospital 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 medical staff committee or governing board?

☐ Yes ☐ No

26. Has your request for any specific clinical privileges 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 medical staff committee or governing board?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

If you answered yes to any question on this application, include the full details on a separate page.

REQUESTED COVERAGE

I am requesting Locum Tenens coverage for the following PRF provider:

a) Full name: ____________________

b) Policy number: ____________________

c) Practice Location(s): ____________________

____

Once approved by PRF, a Locum Tenens (LT) can be used for up to **thirty (30) days** each year. Only one person is insured at any given time, there can be no overlap. A **$100 processing fee** is required with each request for LT coverage.

DATES OF COVERAGE

List the EXACT dates of LT coverage. The days of LT coverage do not need to be consecutive. For example, coverage may be needed for a week in January and for a week in March. Dates not listed will not be covered.

30. The requested dates of LT coverage are:

____

____

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: ____

Signature:____

Date: ____

Please return:

- ☐ Completed application
- ☐ Any additional pages
- ☐ Current CV
- ☐ Claims history for the past ten years
- ☐ Authorization for the Release of Insurance Information
- ☐ HIPAA Business Associate Agreement
- ☐ Sphargis Inc. Share Purchase Agreement

Send to:

Physicians Reimbursement Fund Inc.
A Risk Retention Group (PRF)
3 Harbor Drive, Suite 116
Sausalito, CA 94965

Phone: (415) 332-3041
Fax: (415) 332-3243
Email: info@prfrrg.com
Website: www.prfrrg.com

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 **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: ____

____

____

Physicians Reimbursement Fund, Inc.,
A Risk Retention Group
3 Harbor Drive, Suite 116
Sausalito, CA 94965

Re: Sphargis Inc. Share Purchase

To: Stephen J. Scheifele, MD, MS, President and Chief Executive Officer

The undersigned applicant for professional liability insurance provided by Physicians Reimbursement Fund, Inc., A Risk Retention Group ("PRF") hereby acknowledges the issuance of one share of Class A stock in Sphargis Inc., a California corporation (the "Company") having a par value of $1.00 (One Dollar). The record of ownership will be maintained in the books and records of the Company, and no stock certificate will be issued. I understand that the Company is the corporate parent of PRF, its wholly owned subsidiary.

I acknowledge that my rights and obligations arising from the ownership of this Sphargis Class A share are as described in the Company's Articles of Incorporation as amended and in the Company's Bylaws as amended, copies of which are available upon my request. I understand that these rights include the right to cast a vote for the election of Directors of the Company at its Annual General Meeting of Shareholders.

I also acknowledge that in the event that my coverage with PRF terminates for any reason, my share will automatically be tendered to the Company and its ownership will revert to the Company without the requirement of further action on my part.

Yours truly,

____
Signature

____
Name (Print)

____
Address

____
City/State/Zip Code

____
Phone

____
Date

PHYSICIANS REIMBURSEMENT FUND, INC.,
A RISK RETENTION GROUP

HIPAA BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into by and between ____("Physician Practice") and the Physicians Reimbursement Fund, Inc., A Risk Retention Group ("PRF").

RECITALS

A. WHEREAS, Physician Practice provides medical services in the State of California and may be a Covered Entity under the Health Information Portability and Accountability Act of 1996 ("HIPAA").

B. WHEREAS, PRF is a professional liability insurer with its principal place of business in Sausalito, California, providing professional liability insurance coverage to Physician Practice pursuant to a separate contract of insurance. This agreement is applicable if and only if, and only to the extent that, PRF may be deemed to meet the definition of a Business Associate as defined in the Health Insurance Portability and Accountability Act of 1996, ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"), and amendments and regulations promulgated thereunder by the U.S. Department of Health and Human Services ("DHHS"), as amended from time to time (the "HIPAA Regulations"), and other applicable laws. By signing this agreement PRF does not concede that it is a Business Associate under the terms of the aforementioned laws and regulations, nor does it afford DHHS and its related entities greater jurisdiction over PRF than is mandated by law.

C. WHEREAS, Physician Practice may be required to enter into agreements with its Business Associates in order to appropriately safeguard protected health information that is or may be disclosed to such Business Associates.

NOW THEREFORE, in consideration for the mutual covenants contained below, the parties agree as follows:

TERMS

1. *Definitions*.

a. Agreement means this Business Associate Agreement.

b. Business Associate shall have the meaning given to such term in 45 C.F.R. § 160.103 or successor provisions.

c. C.F.R. shall mean the Code of Federal Regulations.

d. <u>Designated Record Set</u> shall have the meaning given to such term in 45 C.F.R. § 164.501 or successor provisions.

e. <u>Covered Entity</u> shall have the meaning given to such term in 45 C.F.R. § 160.103 or successor provisions.

f. <u>Privacy and Security Laws</u> shall mean HIPAA, HITECH, the HIPAA regulations, particularly 45 C.F.R. Parts 160 and 164, and any other applicable state or federal laws or regulations affecting or regulating the privacy and/or security of health information.

g. <u>Protected Health Information ("PHI")</u> shall have the meaning given to such term in 45 C.F.R. § 160.103 or successor provisions.

2. *Rights and Obligations of PRF as a Business Associate.*

a. <u>Permitted Uses of PHI</u>. PRF may make any and all uses of PHI it obtains or creates in its capacity as a business associate that are necessary to fulfill its legal or contractual obligations as a provider of professional liability insurance to Physician Practice; for the proper management and administration of PRF; or to otherwise carry out PRF's legal responsibilities. PRF may not make any use of PHI except as provided in this Agreement.

b. <u>Permitted Disclosures of PHI</u>. PRF may disclose the PHI it obtains or creates in its capacity as a Business Associate if such disclosure is necessary to fulfill its legal or contractual obligations as a provider of professional liability insurance to Physician Practice; for the proper management and administration of PRF; or to otherwise carry out PRF's legal responsibilities; and:

(1) The disclosure is required by law; or

(2) PRF obtains reasonable assurances from the recipient of the PHI that the PHI will be held confidentially and used or further disclosed only as required by law or with such further authorizations required by law, and any such disclosure shall be only for the purpose for which it was initially disclosed to the recipient; and

(3) The recipient notifies PRF (and PRF in turn notifies Physician Practice) of any instances of which it is aware in which the confidentiality of the PHI has been breached.

c. <u>Access to PHI by Individuals</u>. PRF shall cooperate with Physician Practice to fulfill all requests by individuals for access to the individual's PHI in accordance with 45 C.F.R. § 164.524 and California law.

d. Access to PRF's Books and Records. If mandated by law, PRF shall make its internal practices, books and records relating to the use and disclosure of PHI received from, or created or received on behalf of, Physician Practice available to the Secretary of the Department of Health and Human Services for purposes of determining Physician Practice's compliance with the HIPAA laws and regulations. Upon no less than 15 (fifteen) days written notice to PRF and during PRF's normal business hours, PRF shall make such internal practices, books and records available to Physician Practice to inspect for purposes of determining compliance with this Agreement.

e. Amendment to PHI. PRF shall make PHI received from Physician Practice available for amendment and/or shall incorporate any amendments to PHI requested to be made by Physician Practice in accordance with the requirements of 45 C.F.R. § 164.526 and California law.

f. Disclosure Accounting and Notification. PRF agrees to document any disclosures of PHI as would be required for Physician Practice to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. PRF agrees to provide such documentation to Physician Practice in order to permit Physician Practice to respond to the request. As between Physician Practice and PRF, Physician Practice shall be the entity to provide any required notification of an Individual of breach of privacy of which the law mandates notification.

g. Information Safeguards. PRF shall establish and maintain appropriate safeguards to:

(1) Ensure the confidentiality, integrity, and availability of all PHI PRF creates, receives, maintains, or transmits in its capacity as a Business Associate;

(2) Protect against any reasonably anticipated threats or hazards to the security or integrity of such information;

(3) Prevent any use or disclosure of such information other than as authorized and permitted in this Agreement or by law; and

(4) Ensure compliance with this Agreement by its workforce.

h. Reporting and Mitigating Unauthorized Use or Disclosure. If PRF has knowledge of any use or disclosure of PHI not authorized by this Agreement or otherwise permitted by law, PRF shall promptly notify Physician Practice of any such use or disclosure, and PRF shall use its best efforts to mitigate the deleterious effects of such use or disclosure. PRF likewise agrees that if a pattern of activity or practice by PRF constitutes a material breach or

violation of PRF's obligation under this Agreement, that PRF will rectify that pattern of activity or practice so that it is not in material breach or violation.

i. Affiliates, Agents, Subsidiaries and Subcontractors. PRF shall require that any agents, affiliates, subsidiaries or subcontractors to whom it provides PHI received from, or created or received by PRF on behalf of, Physician Practice agree in writing to the same use and disclosure restrictions as are imposed on PRF by this Agreement.

j. De-identification and Limited Data Sets. PRF may de-identify any and all PHI created or received by PRF from Physician Practice provided that the de-identification practice conforms to the requirements of the Privacy and Security Laws. Such de-identified information will not be subject to the terms of this Agreement. PRF may also create a limited data set as defined in the Privacy and Security Laws, and use such limited data set pursuant to a data use agreement that meets such Privacy and Security Laws.

3. *Obligations of Physician Practice.*

a. Necessary Consents. Physician Practice shall obtain any consent, authorization or permission that may be required by the Privacy and Security Laws prior to furnishing PRF with PHI pertaining to an individual.

b. Notification of Special Arrangements. Physician Practice will inform PRF of any PHI that is subject to any arrangements permitted or required of Physician Practice under the Privacy and Security Laws that may materially affect the use and/or disclosure of PHI by PRF under this Agreement, including, but not limited to, restrictions on the use and/or disclosure of PHI as provided for in 45 C.F.R. § 164.522 and California law.

4. *Term and Termination.*

a. Effective Date. This Agreement shall be effective on the date it is signed by Physician Practice.

b. Term. This Agreement shall terminate on the date that PRF is no longer required to provide services pursuant to any contract of insurance with Physician Practice.

c. Termination for Cause. Either party may terminate this Agreement for a material breach of this Agreement provided the terminating party provides written notice to the breaching party of the specific nature of the breach, and the breaching party fails to cure the breach within 30 (thirty) days after receipt of such notice. The terminating party shall be entitled to terminate any applicable contract of insurance simultaneously with the termination of this Agreement for cause, provided that notice of the intent to terminate such

contract of insurance is given at the same time as notice of the breach of this Agreement.

d. Treatment of PHI on Termination. Within 30 (thirty) days of the termination or expiration of this Agreement, PRF shall return or destroy all PHI received from Physician Practice, including such information in possession of PRF's agents, affiliates, subsidiaries or subcontractors, if feasible to do so. If return or destruction of said PHI is not feasible, PRF will extend any and all protections, limitations and restrictions contained in this Agreement to PRF's use and/or disclosure of any PHI retained after the termination or expiration of this Agreement and limit any further uses and/or disclosures to the purposes that make return or destruction of the PHI infeasible. This Section shall survive any termination or expiration of this Agreement.

5. *Miscellaneous Provisions*.

a. Change in Law. The parties agree to negotiate in good faith to amend this Agreement as necessary to comply with amendments or changes in any provision of the Privacy and Security Laws which materially alters either party's obligations under this Agreement or the Privacy and Security Laws.

b. Construction of Terms. The terms of this Agreement shall be construed in light of any applicable interpretation or guidance on the Privacy and Security Laws issued by the U.S. Department of Health and Human Services, the Office of Civil Rights, or any California Health Services Department.

c. Relation to Other Agreements. In the event that any provision of this Agreement is inconsistent with the terms of any contract between PRF and Physician Practice, the terms of this Agreement shall supersede and control to the extent and only to the extent of such inconsistency, and only to the extent necessary to comply with the Privacy and Security Laws.

d. No Third-Party Beneficiaries. Nothing in this Agreement is intended to or shall confer upon any person other than Physician Practice and PRF and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

e. Governing Law. This Agreement shall be construed broadly to implement and comply with the requirements relating to the Privacy and Security Laws. All other aspects of this Agreement shall be governed under the laws of the State of California. Any dispute arising under this Agreement shall be resolved in accordance with the procedures set forth in the applicable contract of insurance between the parties.

f. Assignment. This Agreement shall inure to the benefit of and be binding upon the parties hereto and their respective legal representatives,

successors and assigns. PRF may assign its rights and obligations under this Agreement to any successor or affiliated entity.

g. Severability. In the event that any provision of this Agreement is determined to be illegal, invalid, unenforceable or otherwise without legal force or effect, the remainder of the Agreement will remain in force and be fully binding.

h. Counterparts. This Agreement may be executed in counterparts with the same effect as though the parties had signed the same document. All counterparts shall be construed together and shall constitute one agreement.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as shown below on the dates shown below.

PHYSICIAN PRACTICE:	PHYSICIANS REIMBURSEMENT FUND, INC., A RISK RETENTION GROUP
By: ______________________	By: ______________________
Name:____________________	Andrea McArtor, Executive Director
Date: ____________________	Date: ______________________