

PHYSICIAN DATA SHEET

1. Physician Name _____

2. Date of Birth _____ SSN# _____

3. Federal DEA# _____

4. License Number _____ State _____ Active: Yes _____ No _____
Expiration _____

5. Professional School Attended _____
(Name) (City/State)

(Year Graduated) (Degree)

6. Additional Training

Internship: _____
(Name) (City/State)

(Type) (Date)

Residency: _____
(Name) (City/State)

(Type) (Date)

Fellowship: _____
(Name) (City/State)

(Type) (Date)

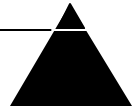
7. Specialty _____

8. Other specialty _____

9. Board Certified: Yes _____ No _____ Name of Board: _____
Date Certified: _____

10. Has your license to practice medicine ever been investigated, suspended or revoked?
Yes _____ No _____ If "Yes", give full details: _____

Executive Risk



11. Have you ever used any intoxicant, narcotic or psychotropic drug to the extent that it has interfered with your ability to perform professional duties?
Yes _____ No _____ If "Yes", explain: _____

12. Has your narcotics license ever been investigated, suspended or revoked?
Yes _____ No _____ If "Yes", give full details: _____

13. Have you ever had your privileges at any hospital or other institution investigated, suspended, revoked, diminished or not renewed?
Yes _____ No _____ If "Yes", give full details: _____

14. Have you ever been indicted or convicted of a felony, not including traffic violations?
Yes _____ No _____ If "Yes", give full details: _____

15. Has any insurer ever cancelled, not-renewed, declined, issued with restrictions or under other special terms your professional liability insurance?
Yes _____ No _____ If "Yes", please state name of insurer and reason for action and dates: _____

16. Have any claims or suits for malpractice been made against you or are you aware of any circumstances which may result in a claim?

17. Yes _____ No _____ If "Yes", please provide a five year claims run from your current insurance carrier, or complete the attached Medical Claims information form for each claim or suit.
Employed _____ Contracted _____

Term _____ To _____

18. Description of Duties _____

19. **Please attach a current declarations page and/or documentation which shows your current retroactive date.**

List the name(s), policy number(s) and policy period(s) for all previous insurance carriers.

<u>Insurance Carrier(s)</u>	<u>Policy Number(s)</u>	<u>Policy Period(s)</u>	<u>Retro Date</u>
a) _____	_____	_____	_____
b) _____	_____	_____	_____
c) _____	_____	_____	_____

I HEREBY DECLARE THAT THE ABOVE STATEMENTS AND PARTICULARS ARE TRUE AND THAT I HAVE NOT SUPPRESSED OR MISSTATED ANY MATERIAL FACTS AND I AGREE THAT THIS APPLICATION SHALL BE THE BASIS FOR THE CONTRACT.

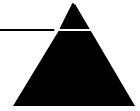
Further, I, the undersigned, hereby authorize and direct any medical society, medical doctor, hospital, insurance company, underwriter, and/or insurance agent to furnish Executive Risk with any information concerning me or my medical practice. I understand that Executive Risk must have access to all possible information concerning my professional life and my personal life to the extent that it affects my professional conduct in order to underwrite professional liability coverage.

I hereby release any person or organization furnishing information to Executive Risk pursuant to this consent and direction, together with the agents, employees or officers of such person or organization from any liability, in any way, for furnishing such information, even if the information may be wrong.

Applicant's Authorized Representative

Position

Date



MALPRACTICE CLAIMS INFORMATION
(Use separate form for each claim)

1. Name of Patient: _____ Sex: _____ Age: _____
2. Allegation and Date of Incident: _____
3. Location: _____
4. Your relationship to the patient (attending physician, ass't surgeon, etc.): _____
5. Insurance Carrier and Policy Number: _____
 _____ Open - Reserve Amount \$ _____
 _____ Closed - Loss Amount \$ _____ Date Closed: _____
 _____ Settlement - Total Amount \$ _____ Your Portion \$ _____
 _____ Judgment - Total Amount \$ _____ Your Portion \$ _____
6. Other Defendants: _____
7. Condition and diagnosis at the time of the incident: _____
8. Description of medical treatment rendered: _____
9. Condition of patient subsequent to treatment: _____
10. To whom may we refer for further information regarding this claim or lawsuit?

I HEREBY DECLARE THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNED: _____ **DATE SIGNED:** _____