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P# \_\_\_\_\_  
UW \_\_\_\_\_

## PHYSICIAN ASSISTANT (PA, PA-C)

### SUPPLEMENTAL APPLICATION/QUESTIONNAIRE

*The purpose of this application/questionnaire is to assist NORCAL Mutual Insurance Company in Determining the increased risk that a health care extender's practice presents to a NORCAL insured physician or entity. Through this application/questionnaire, a health care extender is not eligible for and will not receive individual professional liability insurance from NORCAL Mutual Insurance Company.*

SECTION I TO BE COMPLETED BY PHYSICIAN ASSISTANT.  
SECTION II TO BE COMPLETED BY SUPERVISING PHYSICIAN.

### SECTION I

1. Your full name \_\_\_\_\_  
Date of birth \_\_\_\_\_ Social Security Number \_\_\_\_\_
2. Physician Assistant training program attended \_\_\_\_\_  
Date completed \_\_\_\_\_
3. Name of entity or physician for whom you will be rendering services \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Telephone number ( \_\_\_\_\_ ) \_\_\_\_\_
4. Name of Supervising Physician(s) \_\_\_\_\_
5. Total practice hours per week for the entity or physician listed in Item 3 \_\_\_\_\_
6. Exact date you will begin practicing on behalf of the employer listed in Item 3 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo. Day Year
7. Are you applying for or do you have hospital privileges?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list names of hospitals and extent of privileges granted.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Do you provide any direct patient treatment (not limited to obstetrical care) during delivery (including the immediate labor, puerperium and/or neonatal period) in any place other than a licensed acute care hospital?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain.  
\_\_\_\_\_  
\_\_\_\_\_

### Other Practice Locations

Please list *all* locations at which you currently provide care. (Attach additional pages as needed.)

| Name of Practice | Address | Name of Insurance Carrier | Number of Hours Per Week |
|------------------|---------|---------------------------|--------------------------|
| _____            | _____   | _____                     | _____                    |
| _____            | _____   | _____                     | _____                    |
| _____            | _____   | _____                     | _____                    |

9. Please indicate previous employment as a Physician Assistant. (Give employer’s name and address and dates of employment.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

10. Present insurance carrier, policy number, and expiration date: \_\_\_\_\_

\_\_\_\_\_

### Medical and Insurance History

If you answer “yes” to any of the following questions, you must provide a written narrative and pertinent documentation.

|  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 11. Insurance  |                          |                          |
| Has any professional liability carrier <i>ever</i> cancelled, declined or modified coverage (e.g., reduced limits, assigned a deductible, restricted coverage, surcharged rates) or refused renewal of your insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Governmental Action  |                          |                          |
| a. Has any governmental agency <i>ever</i> investigated you?   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Has any governmental agency <i>ever</i> placed you on probation, suspended, revoked, or taken any other action against your License or your Certificate?  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Have you <i>ever</i> been convicted of a misdemeanor other than a minor traffic violation?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Have you <i>ever</i> been charged with or been convicted of a felony?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Hospital Privileges  |                          |                          |
| a. Have your hospital privileges <i>ever</i> been restricted, suspended, revoked or declined, or has any hospital notified you of its intent to pursue such action?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you <i>ever</i> been under punitive or disciplinary observation, preceptorship or sponsorship in a hospital, or has any hospital notified you of its intent to pursue such action?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| c. At the request of the hospital staff, have <i>ever</i> voluntarily agreed to a modification or termination of your hospital privileges?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Professional Societies   |                          |                          |
| a. Has any physician or patient <i>ever</i> filed a complaint against you with your medical society or with any professional society?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you <i>ever</i> been subject to medical or professional society disciplinary proceedings or review?  | <input type="checkbox"/> | <input type="checkbox"/> |

15. Health

- a. Have you *ever* been diagnosed as having alcoholism, narcotics addiction or mental illness?
- b. Have you *ever* been treated for alcoholism, narcotics addition or mental illness?
- c. Do you have any health problem, illness or physical condition that impairs or could tend to impair your ability to practice your medical specialty?

*If you answer yes to a., b. or c., submit a letter from your treating physician addressing your State of health and whether any condition exists which could adversely affect the practice of your medical specialty.*

16. Other Professional Conduct

Have you *ever* been subject to disciplinary proceedings or to review affecting your participation in a foundation, HMO, PPO, IPA, Medicare or similar entity or have you *ever* been notified of an intent to pursue such action?

17. Claims or Suits

- a. Have you *ever* been notified of your involvement in a malpractice *claim, suit, or incident*, either directly or indirectly?
- b. As of this date, are you aware of any claims or suits made against you or of any conduct, circumstances, occurrences, incidents or accidents that are likely to give rise to claim that has not been reported to your prior insurer(s)?

*If you answer yes to a. or b., complete the attached Claims Information form(s), page 6, and provide a written narrative(s). Include all claims, suits, or incidents including those you have reported to previous professional liability carriers.*

Reminder: *If you answered yes to questions 11 - 17 above, you must provide a written narrative and pertinent documentation.*

18. Other Information

Please disclose any information material to this coverage request which has not otherwise been addressed in the questionnaire (attach additional sheets of paper if necessary)

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I authorize release and exchange of information between NORCAL Mutual Insurance Company and its authorized representatives and my past and present medical association/society(ies) and their insurance consultants, any hospital or other health care facility where I presently hold or previously held staff privileges, prior and current insurance carriers, government agencies, educational institutions and any other entities or individuals NORCAL Mutual Insurance Company deems necessary to contact in its evaluation of past and future underwriting and claims matters. I agree that the organization releasing the information and its agents, servants, and employees, shall not incur any liability as a result of any information released or furnished pursuant to this authorization, including any errors, omissions or mistakes contained in such released information.

I represent and warrant the truth of my statements and information mentioned herein, and that I have not misrepresented, omitted or concealed any material fact which is reasonably likely to influence the judgment of NORCAL Mutual Insurance Company in considering this coverage request.

I understand that the purpose of this application/questionnaire is to assist NORCAL Mutual Insurance Company in determining the increased risk my practice presents to NORCAL insured physician or entity. I further understand that through this application/questionnaire, I am not eligible for and will not receive individual professional liability insurance from NORCAL Mutual Insurance Company.

Signature \_\_\_\_\_ Date \_\_\_\_\_

SECTION II

(To be completed by supervising physician[s])

19. Name \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone Number ( \_\_\_\_\_ ) \_\_\_\_\_

20. Will the Physician Assistant practice solely at the above address? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, please explain.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

21. What percentage of patients seen by the Physician Assistant will be seen by you as a matter of routine? \_\_\_\_\_%

22. What is your daily patient volume? \_\_\_\_\_  
a. What is the Physician Assistant's daily patient volume? \_\_\_\_\_

23. Will the Physician Assistant be authorized to dispense and/or prescribe drugs?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain under what conditions.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

24. When will the charts of patients, for whom prescription drugs have been ordered, be reviewed and initialed by you?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

25. Does the Physician Assistant ever take call on your behalf or on behalf of a physician in your call rotation?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain in detail under what circumstances this occurs.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

26. Will the Physician Assistant provide prenatal or postnatal care? Yes \_\_\_\_\_ No \_\_\_\_\_

27. Will the Physician Assistant perform deliveries? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, complete the remaining questions. If no, please continue with question 31.

28. How many deliveries do you perform on a monthly basis? \_\_\_\_\_  
a. How many deliveries are performed by the Physician Assistant on a monthly basis? \_\_\_\_\_  
b. Please indicate the percentage of high risk and low risk deliveries performed by the Physician Assistant.  
\_\_\_\_\_ % high risk \_\_\_\_\_ % low risk

29. How often will charts of patients seen by the Physician Assistant be reviewed by you? \_\_\_\_\_

30. What percentage of patients to be delivered by the Physician Assistant is seen by you:

- a. In first trimester? \_\_\_\_\_ %
- b. In second trimester? \_\_\_\_\_ %
- c. In third trimester? \_\_\_\_\_ %

NOTE: Please submit evidence of the Physician Assistant’s advanced training in obstetrics (to include prenatal, intra-partum and post-partum training, didactic, clinical and graduate experience) with this questionnaire.

31. Please list all other Non-Physician Health Care Providers you supervise, employ or with whom you contract.

| Title                          | Number with whom you work | Name of provider(s) |
|--------------------------------|---------------------------|---------------------|
| Physician Assistant (PA, PA-C) | _____                     | _____               |
| Nurse Practitioner             | _____                     | _____               |
| Nurse Midwife                  | _____                     | _____               |

32. Other Information

Please disclose any information material to this coverage request which has not otherwise been addressed in the questionnaire (attach additional sheets of paper if necessary).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NOTE: The following material *must* be submitted with this application/questionnaire.

**FOR CALIFORNIA POLICYHOLDERS**

1. Copy of the protocol used by the Physician Assistant in *your* practice. The protocol must list the specific conditions and diseases the Physician Assistant is authorized to treat, as well as show the degree of your supervision. The protocol must be signed and dated by both the Physician Assistant and you;
2. Certificate of approval (to supervise a Physician Assistant) from the Medical Board of California (MBC); and
3. Physician Assistant License (from the Physician Assistant Examining Committee of MBC).

**FOR OREGON POLICYHOLDERS**

1. Copy of Physician Assistant Practice Description;
2. Copy of the approval letter from Board of Medical Examiners (BME); and
3. Physician Assistant Certificate (from National Commission for the Certificate of Physician Assistants)

**FOR ALASKA POLICYHOLDERS**

1. Copy of Collaborative Agreement between the Physician Assistant and the physician supervisor(s); and
2. Physician Assistant License.

I represent and warrant that I have read the contents of this questionnaire and having done so affirm that the responses made in this questionnaire are true and correct to the best of my knowledge.

Signature \_\_\_\_\_ Date \_\_\_\_\_

P# \_\_\_\_\_  
UW \_\_\_\_\_

CLAIMS INFORMATION

NOTE: All questions must be answered completely. Attach additional sheets as required.

Name of Patient \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Allegation \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Relationship to Patient (i.e., attending physician, surgeon, assistant surgeon, consultant, etc.)

\_\_\_\_\_

Date of Incident \_\_\_\_\_ Location of Incident \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Date Reported \_\_\_\_\_

Additional Defendants \_\_\_\_\_

Claim Suits  Open  
 Closed Date \_\_\_\_\_

If closed, indicate:

a. Method of closing:  Dismissed  Settled  Judgment

b. Amount of settlement or judgment \_\_\_\_\_

Describe your care and treatment of the patient. (Use the space on the following page or attach additional sheets.) Your narrative must provide adequate clinical detail to allow proper evaluation by a committee of physicians and include the following information:

- a. Condition and Diagnosis at Time of Incident
- b. Dates and Description of Treatment Rendered
- c. Condition of Patient Subsequent to Treatment
- d. Copies of Patient(s) Chart(s) and Operative Report(s) as appropriate

\_\_\_\_\_  
\_\_\_\_\_

I understand information submitted herein becomes part of my Professional Liability Insurance Application as submitted.

Signature \_\_\_\_\_ Date \_\_\_\_\_

