National Fire & Marine Insurance Company

Omaha, Nebraska

LOCUM TENENS & CONTRACT STAFFING ORGANIZATIONS APPLICATION

PROFESSIONAL AND GENERAL LIABILITY

I. GENERAL INFORMATION

A. _____

Name of Applicant Organization

_____ _____ _____ _____ _____

Mailing Address/Principal Business Address **City** **County** **State** **Zip Code**

_____ _____-_____-_____ _____-_____-_____

Email Address **Phone** **Fax**

_____

Website Address

B. Select the appropriate organization:

- □ **Sole Proprietor**
- □ **Corporation**
- □ **Limited Liability Corporation**
- □ **Other** _____

C. Does the applicant organization operate under any other name? □ Yes □ No

If Yes, please provide the name: _____

D. In what year did the applicant organization begin operations? _____

E. Number of years operated by the current management: _____

F. Does the applicant organization have:

1. **A Medical Director?** □ Yes □ No
   If Yes, please provide the contact information: _____ _____-_____-_____
   Name **Phone**
2. **A Credentialing contact?** □ Yes □ No
   If Yes, please provide the contact information: _____ _____-_____-_____
   Name **Phone**
3. **A Claims Management contact?** □ Yes □ No
   If Yes, please provide the contact information: _____ _____-_____-_____
   Name **Phone**
4. **Risk Management contact?** □ Yes □ No
   If Yes, please provide the contact information: _____ _____-_____-_____
   Name **Phone**

G. Number of W-2 employees: Full Time _____ **Part Time** _____

H. Number of Non W-2 employees: Full Time _____ **Part Time** _____

I. Does the applicant organization qualify for "Covered Entity" status under the Health Insurance Portability and Accountability Act of 1996 (HIPPA)? □ Yes □ No

If Yes, is the applicant organization in compliance? □ Yes □ No

Privacy Officer: _____

Attachments necessary to complete this application:

1. Curriculum Vitae (CV) for each of the following members of the applicant organization: Medical Director, Claims Manager & Risk Manager
2. Claims and risk management protocols
3. Current annual financial statements
4. Healthcare provider contract sample
5. Healthcare facility contract sample

II. PROFESSIONAL SERVICES

A. Type of organization:

□ Locum Tenens Organization
□ Contract Staffing Organization

B. Estimate the annual gross revenue of the applicant organization for the next twelve months: $ _____

C. Applicant organization's annual gross revenue for the last twelve months: $ _____
Applicant organization's annual gross revenue for the first prior year: $ _____

D. Are healthcare providers staffed by the applicant organization in any Patient Compensation Fund state? □ Yes □ No

If Yes, list all states applicable: _____

E. Are healthcare providers staffed by the applicant organization in:

New York? □ Yes □ No
Virginia? □ Yes □ No

III. LOCUM TENENS If Contract Staffing Organization, please skip to Section IV., Contract Staffing.

A. Indicate the facility type where the applicant organization provides staffing services. Check all applicable and provide percentages totaling 100%:

□ Hospital _____% □ Correctional Facility _____% □ Surgery Center _____% □ Clincial Trial _____% □ Nursing Home ____%
□ Clinic _____% □ FTCA—Eligible Clinic _____% □ Physician Office _____% □ Other_____ ____%

B. Are all W-2 and Non W-2 employees who will not be covered by this medical professional liability insurance required to carry medical professional liability insurance coverage applicable to their professional activities? □ Yes □ No

If Yes, does the applicant organization verify coverage? □ Yes □ No

What are the limits of liability required by the applicant organization? _____ each claim / _____ aggregate

C. Is the applicant organization a member of any professional locum tenens associations? □ Yes □ No

If Yes, please list: _____

D. If the applicant organization has been in business more than one year, provide the annual aggregate locum placement days for all specialties. One placement day = 8 hours for all specialties except Emergency Medicine, Hospitalist & Neonatology, where one day = 12 hours.

Current year:_____
First prior year:_____
Second prior year:_____
Third prior year:_____
Fourth prior year:_____

E. Complete the attached Locum Tenens Medical Specialties Supplement.

IV. CONTRACT STAFFING If Applicant is a Locum Tenens Organization, please skip to Section V., Risk Management Procedures.

A. List the name, address and services rendered to all currently contracted or planned contracts during the next 12 months:

Name	Address	Services

B. Are locum tenens services used by the applicant organization to fulfill any contract obligations? □ Yes □ No

If Yes, does the applicant organization require medical professional liability insurance? □ Yes □ No

What are the limits of liability required by the applicant organization? _____ each claim / _____ aggregate

C. Complete the attached Contract Staffing Supplement.

V. RISK MANAGEMENT PROCEDURES

A. Does the applicant organization have a formal risk management program? □ Yes □ No
If No, does the applicant organization plan to implement a formal program in the next twelve months? □ Yes □ No

B. Does the applicant organization credential its own providers? □ Yes □ No
Check all of the following employment screening guidelines applicable to the provider screening process:

_____ Application	_____ Disciplinary actions	_____ Validate current licenses/certifications
_____ Drug Test	_____ Sex abuse registry	_____ Validate work history/education
_____ Reference Check	_____ Criminal background check	_____ Validate claims history
_____ Personal interview	_____ Other _____	

C. If a job applicant falls outside the employment screening guidelines will the applicant organization's Medical Director make the final determination of eligibility? □ Yes □ No
If No, please explain _____

D. Is the initial employment period on a probationary basis? □ Yes □ No

E. Does the applicant organization create a practice profile for W-2 and Non W-2 healthcare providers prior to assignment in each facility? □ Yes □ No

F. Is the applicant organization accredited by any credentialing organization? □ Yes □ No
If yes, list all _____

G. Are all W-2 and Non W-2 healthcare providers licensed in all states where services are rendered, including electronic communication exchange (telemedicine)? □ Yes □ No

H. Are the recruitment and credentialing of healthcare providers carried out by separate individuals? □ Yes □ No

I. Does the applicant organization have an incident reporting process? □ Yes □ No

J. Does the applicant organization monitor the quality of care provided by its W-2 and Non W-2 employees? □ Yes □ No

K. Are claims reviews conducted as part of the risk management process? □ Yes □ No

VI. GENERAL LIABILITY

Does the applicant organization desire general liability coverage? □ Yes □ No
If No, skip to Section VII.

A. Please list the following for each of the applicant organization's faciliites:
Name, address, square footage, year built, year remodeled, number of stories, type of construction, percentage of building occupied by applicant organization, and number of additional occupants

1. _____
2. _____
3. _____
4. _____

B. Does the applicant organization maintain a garage? □ Yes □ No

If Yes, please list the square footage of all parking facilities owned or rented by the applicant organization. _____

_____

C. Are all of the applicant organization's locations equiped with:

1. Complete sprinkler system? □ Yes □ No
2. At least two clearly marked exits on each floor? □ Yes □ No
3. Smoke detectors? □ Yes □ No
4. Emergency electircal system? □ Yes □ No
5. Heat sensors? □ Yes □ No
6. Fire escape(s)? □ Yes □ No
7. Posted emergency evacuation procedures? □ Yes □ No
8. Properly maintained fire extinguishers? □ Yes □ No

D. Do any of the applicant organization's locations:

1. Have exposure to flammables, explosives, or chemicals? □ Yes □ No
2. Have catastrophe exposure? □ Yes □ No
3. Have exposure to radioactive materials? □ Yes □ No
4. Store, treat, discharge, apply, dispose of, or transport, hazardous materials? □ Yes □ No
5. Have a written safety program in place? □ Yes □ No

If Yes to any of the above, please provide details by attachment.

E. Does the applicant organization sell or lease any medical equipment or products to patients or others in connection with it's operations? □ Yes □ No

If Yes,

1. Total annual sales $_____
2. Total annual/lease rental receipts $_____
3. Who is responsible for the preventative maintenance, inspection and repair of the equipment? _____

_____

F. Does the applicant organization:

1. Own any elevators or escalators? □ Yes □ No
2. Own or rent any parking facility? □ Yes □ No
3. Provide any recreational facility? □ Yes □ No
4. Have a swimming pool on the premises? □ Yes □ No
5. Sponsor any sporting or social events? □ Yes □ No
6. Own or rent space used for housing for any healthcare provider? □ Yes □ No

If Yes to any of the above, please provide details by attachment.

G. Does the applicant organization use an advertising agency? □ Yes □ No

If Yes:

1. What are the minimum professional liability limits required? $_____ /$_____
2. Is the applicant organization included as an additional insured on the advertising agency's policy? □ Yes □ No
3. Is there a hold harmless agreement in the contract in favor of the applicant organization? □ Yes □ No

H. Does the applicant organization have written procedures for incident reporting? □ Yes □ No

VII. COVERAGE HISTORY AND INFORMATION

A. Please provide the applicant organization's insurance history for the last five years.

Policy Period	Most Recent Year	1 Year Prior	2 Years Prior	3 Years Prior	4 Years Prior
Professional Liability					
Insurance Company					
Limits					
Claims-Made (CM) or Occurrence (O)					
Premium					
General Liability					
Insurance Company					
Limits					
Claims-Made (CM) or Occurrence (O)					
Premium					

VIII. LOSS INFORMATION (IMPORTANT! FULLY COMPLETE)

For each claim, potential claim or suit mentioned below, please complete the Loss Information Supplemental Application.

A. Has the applicant organization (independently or through a named insured) been involved now or in the past, directly or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services involving former or present partners, members of the corporation or any former or present employee or independent contractor of the applicant organization or any affiliated person or entity? □ Yes □ No

If Yes, how many? _____

If Yes, have these been reported to the applicant organization's insurer? □ Yes □ No

B. Does the applicant organizaiton or any of its employees/contractors have knowledge of any incident, or unexpected adverse outcome resulting in injury or death, claim, potential claim, or suit in which the applicant organization may become involved, including without limitation, knowledge of any injury arising out of the rendering, or failing to render, professional services which may give rise to a claim involving former or present partners, members of the corporation, or any former or present employee or independent contractor of the applicant organization? □ Yes □ No

If Yes, how many? _____

If Yes, have these been reported to the applicant organization's insurer? □ Yes □ No

IX. NOTICES AND AGREEMENTS

Any person who knowingly and with intent to injure, deceive, or defraud any insurance company or other person files an application for insurance containing any materially false information or fails to provide complete information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may be prosecuted under state law and may be guilty of a felony and subject to criminal and civil penalties, fines, denial of insurance or confinement in prison.

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (hereinafter "Attachments") for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any Attachments, shall be the basis of the contract with the Company. I agree to notify the Company if there are any future material changes in any answer to this application, or its Attachments, including without limitation, any change in my professional specialty, affiliation or working arrangement with any other dentist, physician, firm or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and void and without effect or provide the Company the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I agree that if I fail to comply with these terms I will have no coverage for any claim under any policy of insurance for which I am applying.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

I warrant that I am authorized to disclose all information that I may submit or which I may authorize others to submit in connection with this application, including authority to disclose such information under federal and state privacy protection statutes and regulations.

By signing this application on behalf of an entity (which may include a professional corporation, a professional association, a limited liability company, a general business corporation, a partnership, a joint venture, or a governmental entity), I warrant that I am an Officer, Partner, Office Administrator or other Authorized Representative of the entity applying for coverage.

Application must be signed by a President, Chief Executive Office, or other Officer or Partner of a PC or PA or the Office Administrator or equivalent Authorized Representative.

Authorized Representative Signature	Print Name	Date Signed (MM/DD/YYYY)

X. SUPPLEMENTAL INFORMATION

NATIONAL FIRE & MARINE INSURANCE COMPANY
LOSS INFORMATION SUPPLEMENTAL APPLICATION

LOSS HISTORY

If the applicant organization has been insured with The Medical Protective Company or National Fire & Marine Insurance Company for less than ten years or if the applicant organization's facility participated in a self-insured retention arrangement, provide a recently valued claims exhibit for all claims during the last ten full years. However, provide only the claims information on those claims which are not being handled directly by The Medical Protective Company or National Fire & Marine Insurance Company.

THE LOSS INFORMATION SHOULD ADDRESS BOTH THE APPLICANT ORGANIZATION'S PROFESSIONAL AND GENERAL LIABILITY INSURANCE CLAIMS EXPERIENCE INCLUDING PAID AND RESERVED AMOUNTS.

If making additional copies, please enter the applicant organizations's name here: _____

NOTE: Additional documentation (office/hospital records) may be requested at our discretion.

Claim Number: _____

A. Claimant Name: _____ Age: _____

B. Date of treatment and/or surgery, which led to the allegations against the applicant organization: ____ ____ (MM YYYY)

C. Date claim/incident notice received: ____ ____ (MM YYYY)

D. Name of doctor(s), health care providers(s) or other hospital(s) if any, involved in the claim or suit:

_____

E. Name of defending insurance carrier that defended claim:

_____

F. Was a claim made or a suit filed? ☐ Yes ☐ No

G. Disposition or current status of claim or suit: ☐ Open ☐ Closed

If closed, date of closing/settlement or award: ____ ____ (MM YYYY)

If closed, was payment made? ☐ Yes ☐ No

If no, was claim or suit withdrawn? ☐ Yes ☐ No

Amount paid on applicant organization's behalf: $ _____

Total amount of settlement or award: $ _____

Was this matter closed with applicant organization's consent? ☐ Yes ☐ No

If open, has settlement been offered? ☐ Yes ☐ No

If open, has trial date been set? ☐ Yes ☐ No

Trial date: ____ ____ (MM YYYY)

H. Nature of allegations in the claim or suit:

Condition treated: _____

Treatment provided: _____

Alleged negligence: _____

Alleged injury: _____

I. Please provide a narrative description of the medical facts: (Must include, but not limited to the type of treatment and/or surgery, including applicant's level of involvement).

_____

_____

National Fire & Marine Insurance Company

Omaha, Nebraska

LOCUM TENENS MEDICAL SPECIALTIES SUPPLEMENT

SCHEDULE OF MEDICAL SPECIALTIES FOR HEALTHCARE PROVIDERS

Note: For exposure in multiple states, please show details for each state. If more space is needed, please make additional copies.

Class	Specialties	State Placement(s)	Current Year Days	Estimated Days Next 12 Months
1A	Aerospace Medicine, Allergy, Occupational Medicine, Physiatry, Pyschiatry - Incl. Child			
1B	Dermatology - No Surgery/Minor Surgery, Endocrinology - No Surgery/Minor Surgery, Geriatrics - No Surgery/Minor Surgery, Rheumatology			
1C	Family/General Practice - No Surgery, Hematology/Oncology - No Surgery/Minor Surgery, Internal Medicine - No Surgery, Nephrology - No Surgery/Minor Surgery, Ophthalmology, Pathology - No Surgery/ Minor Surgery, Pediatrics - No Surgery			
2A	Anesthesiology, Otorhinolaryngology - No Surgery/Minor Surgery, Pain Management, Pain Medicine, Radiation Therapy/Radiation Oncology			
2B	Cardiology - Swan-Ganz & Right Heart Cath., Neurology - No Surgery, Pediatrics - Minor Surgery, Urgent/Ambulatory Care			
3A	Family/General Practice - Minor Surgery, Gastroenterology, Hospitalist, Infectious Diseases - No Surgery/Minor Surgery, Pulmonary Diseases			
3B	Diagnostic Radiology - No Surgery/Minor Surgery, Internal Medicine - Minor Surgery, Urology			
4A	Intensive Care Medicine, Neonatology, Otorhinolaryngology - Surgery			
4B	Cardiology - w/ Left Heart Cath., Colon & Rectal Surgery, Correctional Medicine - No Federal Facilities, Family/General Practice - w/ Deliveries, Oral Surgeon			
5A	Gynecology - Surgery, Neurology - Minor Surgery			
5B	Correctional Medicine - Federal Facilities, Emergency Medicine - No Major Surgery, Orthopedic Surgery, Plastic Surgery			

Class	Specialties	State Placement(s)	Current Year Days	Estimated Days Next 12 Months
6	Abdominal Surgery, Cardiovascular Surgery, Emergency Medicine - Major Surgery, General Surgery, Thoracic Surgery, Vascular Surgery	_____ _____ _____	_____ _____ _____	_____ _____ _____
7A	Obstetrics/Gynecology	_____ _____ _____	_____ _____ _____	_____ _____ _____
7B	Trauma Surgery	_____ _____ _____	_____ _____ _____	_____ _____ _____
8	Neurological Surgery	_____ _____ _____	_____ _____ _____	_____ _____ _____
Allied_2	Nurse - NOC	_____ _____	_____ _____	_____ _____
Allied_3	Pharmacist, Physical Therapist	_____ _____	_____ _____	_____ _____
Allied_4	Psychologist	_____ _____	_____ _____	_____ _____
Allied_5A	Nurse Practitioner	_____ _____	_____ _____	_____ _____
Allied_5B	Physician Assistant	_____ _____	_____ _____	_____ _____
Allied_5C	Chiropractor, General Dentist	_____ _____	_____ _____	_____ _____
Allied_6	Certified Registered Nurse Anesthetist, Anesthesia Assistant	_____ _____	_____ _____	_____ _____
Allied_7	Nurse Midwife	_____ _____	_____ _____	_____ _____
Allied_8	Podiatrist	_____ _____	_____ _____	_____ _____

One placement day = 8 hours for all specialties except Emergency Medicine, Hospitalist & Neonatology where one day = 12 hours.

National Fire & Marine Insurance Company

Omaha, Nebraska

CONTRACT STAFFING SUPPLEMENT

		Emergency Room (ER) or Urgent Care (UC) Staffing						Hospitalist Staffing		Correctional Staffing ADI = Average Daily Inmate			
		Current Annual No. Visits		Projected Annual No. of Visits		Current/ Projected Annual FTEs ER	Current/ Projected Annual FTEs UC	Current/ Projected FTEs or Unique Patient Encounters	Projected FTEs or Unique Patient Encounters	Current ADI	Projected ADI	Current/ Projected Annual FTEs	Current/ Projected Annual FTEs
State	Name of Facility	ER	UC	ER	UC	Physician	NP or PA	Physician/NP or PA	Physician/NP or PA			Physician	NP or PA
						/	/	/	/				

FTE = "Full time equivalent" means the total number of provider hours equal to 1 full time provider; a full-time provider is defined as 8 hours per day for all specialties except for Emergency Medicine, Hospitalists, and Neonatologists, where 1 day equals 12 hours

	Radiology Staffing				
State	Name of Facility	Number of Annual Reads	Number of Projected Annual Reads	Current FTE's	Projected FTEs

RADIOLOGY STAFFING

Please list states where teleradiology services are provided and indicate approximate percentage of reads per state _____

Are valid medical licenses or a state-issued special purpose medical license held for all jurisdictions from which images are transmitted for radiologic interpretation? _____

Schedule of Individual Healthcare Providers

Name of Provider	Medical Specialty	Location	Provider's Start Date	Provider's End Date