

ALLIED MEDICAL PSYCHIATRIST SUPPLEMENTAL APPLICATION

A. GENERAL INFORMATION:

1. Name of Clinic/Center: _____
2. Do you serve as the Medical Director or Chief of Psychiatry at this location? Yes No
3. Do you teach at this location? Yes No

B. PROFESSIONAL TRAINING:

1. List the professional societies of which you are a member: _____

2. License Number(s) and State(s): _____
3. Medical School Attended: _____ Country: _____
Year Graduated: _____ Degree: _____
4. If you are a graduate of a non-US medical school, have you obtained an ECFMG Certificate? Yes No
5. Are you Board Certified in any of the following specialties?

Yes	No	Specialty	Date Attained <small>(mm/dd/yy)</small>
<input type="checkbox"/>	<input type="checkbox"/>	General Psychiatry	
<input type="checkbox"/>	<input type="checkbox"/>	Child & Adolescent Psychiatry	
<input type="checkbox"/>	<input type="checkbox"/>	Geriatric Psychiatry	
<input type="checkbox"/>	<input type="checkbox"/>	Administrative Psychiatry	
<input type="checkbox"/>	<input type="checkbox"/>	Other (Specify):	

6. a. How many hours per week do you spend in active practice for Clinic/Center? _____
b. How many weeks per year do you spend in active practice for Clinic/Center? _____
7. a. Have you successfully completed psychoanalytic training? Yes No
b. If Yes: Date attained: _____
c. Average weekly # of total practice hours: _____
d. Average weekly # of psychoanalytical hours: _____

C. PRACTICE PROFILE: Please attach a separate sheet for any required explanations.

1. a. Do you sign insurance or other reimbursement forms for patients where you have not participated in their care and treatment? Yes No
b. If Yes, please describe in what capacity (e.g., as a Medical Director) and indicate if you clarify what your signature means on such forms. _____

2. a. Do you create and maintain a psychiatric/medical record for each patient under your care? Yes No
 b. If No, please explain: _____
3. Do you prescribe controlled substances? Yes No
4. Do you obtain an informed consent, whether signed by patient or noted in chart, before prescribing, especially when prescribing neuroleptics? Yes No
5. a. Do you write prescriptions for patients you have not clinically evaluated other than to cover for another colleague whose patient requires a minimal refill on an existing prescription? Yes No
 b. If Yes, please explain under what circumstances: _____
6. a. Do you treat patients with unconventional therapy, i.e., treatment not considered to be mainstream psychiatric treatment? Yes No
 b. If Yes, please describe: _____
7. a. Do you perform electro-convulsive therapy for the center named above (ECT)? Yes No
 b. Where is this procedure performed? _____
 c. Is Anesthesia always administered in a licensed Medical facility? Yes No
 d. Who administers Anesthesia?
 Anesthesiologist CRNA Other: (explain): _____

D. CLAIM INFORMATION

1. Have you ever been:
 a. The subject of an investigatory or disciplinary proceeding or reprimand? Yes No
 b. Have you been charged with, convicted of, or pleaded guilty or no contest to a felony? Yes No
 c. Treated for alcoholism or drug addiction? Yes No
2. Have you ever been, or are you currently, either sexually, romantically, or socially involved with any current, or former, patient or with a family member of a patient? Yes No
3. Have you ever had a settlement or judgment alleging undue familiarity, professional misconduct, or assault in connection with undue familiarity? Yes No
4. a. Have you ever had a malpractice claim or suit filed against you? Yes No
 b. If Yes, how many? _____
5. a. Do you know of any incident that may result in a claim against you? Yes No
 b. If Yes, for each claim, suit, or incident, complete a separate claim activity form.

E. INSURANCE

1. a. Has any insurance company ever declined, failed to renew, conditionally renewed or cancelled a Professional Liability Policy for you? Yes No
 b. If Yes, please list company, date, and reason for the action by the company: _____
2. a. Apart from the insurance provided by your employer, do you carry your own professional liability insurance? Yes No
 b. If Yes, what is the name of your insurer? _____
 c. Policy Number: _____
 d. Policy Dates: _____ Limits: _____

3. a. Is coverage: Occurrence Claims Made
- b. If Claims Made, what is retroactive date? _____
- c. Does this malpractice policy cover you for your acts at the center? Yes No

F. DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

Applicant's Signature

Sub-Producer

Title

Date

Producer

*SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPLETE THE INSURANCE. Application MUST be currently signed and dated to be considered for quotation.