Physicians and Surgeons Professional Liability Application - *Locum Tenens*

Refer to [www.lammico.com](http://www.lammico.com) for a downloadable version of this application.

It is recommended that you submit your application at least 30 to 45 days in advance of your desired effective date in order to ensure a timely review of your application. Please read the following instructions in order to expedite the review of your application:

1. Answer all questions or mark "N/A" where appropriate;
2. Submit all information as requested by the application if a claim or suit has been filed against you.
3. Sign and date your application on page 4.

Pursuant to the HIPAA Privacy Regulations, LAMMICO will maintain the confidentiality of any medical information forwarded in response to number (2) above, use it only for the purposes for which it was disclosed or as required by law, and notify you of any breach of confidentiality of the medical information of which we become aware.

When completed, please return this application to:

**Louisiana Medical Mutual Insurance Company**  
**One Galleria Blvd., Suite 700**  
**Metairie LA 70001-7510**  
**FAX: 504/841-5205 or 504/841-5300**

If you have questions, please call the Underwriting Department at 504/831-3756 or 800/452-2120. Thank you for your interest in LAMMICO. We look forward to serving your professional liability insurance needs.
Physicians and Surgeons Professional Liability Application - Locum Tenens

Any physician who takes over the practice of another physician on a temporary basis must complete a locum tenens application. Limits of the LAMMICO insured are shared with the locum tenens physician.

### Personal Information

<table>
<thead>
<tr>
<th>Name of Locum Tenens</th>
<th>Application # (LAMMICO use only)</th>
<th>Name of LAMMICO Insured</th>
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<tr>
<th>Office Address (city, state, zip)</th>
<th>Years at this Location</th>
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<tr>
<th>Billing Address (city, state, zip)</th>
<th>Other Locations (if any)</th>
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<thead>
<tr>
<th>Home Address (include city, state, zip)</th>
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<tr>
<th>Medical Group Name (if any)</th>
<th>Social Security No.</th>
<th>Date of Birth</th>
<th>Parish Medical Society</th>
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<tr>
<th>Office Phone</th>
<th>Fax Number</th>
<th>Home Phone</th>
<th>E-mail Address</th>
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Desired Coverage Period (Period you will be temporarily serving in the LAMMICO insured's place)

### Underwriting and Rating Information

1.a. Do you have a current license to practice medicine in LA? [ ] Yes [ ] No LA License No.: ____________________________

1.b. State and Federal Narcotics License Numbers: ____________________________________________

1.c. Do you have any restrictions? (if yes, explain) [ ] Yes [ ] No

2. List other states where licensed and license #s:

3. Undergraduate School, Location

<table>
<thead>
<tr>
<th>Medical School, Location</th>
<th>Degree</th>
<th>Year</th>
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<tr>
<th>Postgraduate Training, Location</th>
<th>Degree</th>
<th>Year</th>
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Served Internship at (PG I) Year(s)

Served Residency at (PG II - ?) Year(s)

4. Are you certified by an approved specialty board? (if yes, which?) [ ] Yes [ ] No

5. What is your medical specialty?

NOTE: If your medical specialty is not the same as the LAMMICO insured's specialty, please describe in the remarks section the duties you will be performing while substituting for the LAMMICO insured.

6. Will you perform or assist in surgery? [ ] Yes [ ] No If yes, will this be confined to the LAMMICO insured's patients? [ ] Yes [ ] No

7. Medical or Surgical Procedures (Please indicate whether you perform any of the following):

- [ ] Anesthesia
  - General
  - Spinal
  - Epidural
- [ ] Assisting in major surgical procedures
- [ ] Minor Surgery & Procedures - Includes operations and procedures not considered to be major surgery, involving primary treatment of limited abnormalities, injuries, and infections of the skin and superficial tissue, usually using local anesthesia and predominantly performed on an outpatient basis. It includes but is not limited to the following list. Check all applicable:
  - No procedures-only consulting or diagnostic
  - Incisions of boils and superficial abscesses
  - Suturing of skin and superficial fascia
  - Cryosurgery
  - On benign dermatological lesions
  - Other ____________________________

Rev. 05/19/03 Locum Tenens Application
Acupuncture-other than acupuncture anesthesia
Angiography
Angioplasty
  □ Coronary
  □ Peripheral
Bone fractures: closed treatment
Cancer chemotherapy
Catheterization
  □ Cardiac
  □ Transarterial
  □ Occasional insertion of pulmonary wedge, recording catheters, or temporary pacemakers
  □ Transvenous
Umbilical cord catheterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen (other than emergency or for transport)
Cervical conization-specify type: ____________________________
Circumcision
Colonscopy
Cosmetic injections-specify type: ____________________________
Cosmetic/reconstructive skin flaps and skin grafts
Major Surgery—Includes operation procedures in or upon any body cavity including cranium, thorax, abdomen, pelvis; any other operations or procedures which, because of the condition of the patient or the length or circumstances of the operation, present a distinct hazard to life. It also includes but is not limited to the following list. Check all applicable:

Amputations
Bone fractures
Fertility or reproductive surgery
Gynecological procedures
Laparoscopic Cholecystectomy
Laparoscopy
Liposuction
Minimal invasive endoscopic surgery-specify type: ____________________________
Obesity surgery-specify type: ____________________________
Obstetrical procedures
  □ Abortions
  □ Cesarean sections
  □ Forceps delivery other than outlet forceps
  □ Elective
  □ Home delivery
  □ Therapeutic
  □ Vaginal delivery
  □ Other
Penile implants
Percutaneous disc surgery
Plastic surgery
  □ Cosmetic-specify type: ____________________________
  □ Reconstructive-specify type: ____________________________
  □ Facial-specify type: ____________________________
Radial keratotomy
Dermabrasion
Diagnostic sonography
Discograms
Electroshock therapy (psychiatric)
Fiberoptic bronchoscopy
Hair transplant
Interventional endoscopy-specify type: ____________________________
Laser therapy-specify type: ____________________________
Needle biopsy
Needle biopsy
  □ Lung, liver, kidney, or prostate
  □ Bone Marrow
  □ Other-specify type: ____________________________
Nerve blocks, therapeutic-specify type: ____________________________
Pneumatic or mechanical esophageal dilation (not with bougie or olive)
  □ Radiopaque contrast material injections into blood vessels, lymphatic, sinus tracts, and fistulae
Vasectomy
Other
Other-specify type: ____________________________
8. Has any hospital or medical staff ever restricted or revoked your privileges or invoked probation?  
☐ Yes ☐ No

9. Has your license to practice medicine or narcotics license ever been revoked, voluntarily suspended, or subjected to probation/restrictions or are you aware of any circumstances that might lead to such?  
☐ Yes ☐ No

10. Has your membership in any medical association or society ever been refused, suspended, revoked, voluntarily surrendered or been censured?  
☐ Yes ☐ No

11. Have you been treated for substance abuse or participated in an impaired physician program?  
☐ Yes ☐ No

12. Have you now or have you ever had a chronic illness or physical defect that impairs or could tend to impair your ability to practice medicine?  
☐ Yes ☐ No

13. Have you been convicted of a crime (other than a motor vehicle violation)?  
☐ Yes ☐ No

14. Have fee complaints or professional relations complaints been registered against you with your medical society/association or state licensing authority within the past five years?  
☐ Yes ☐ No

15. Has your professional liability insurance ever been cancelled, non-renewed, restricted or surcharged, or has your professional liability insurer ever asked you not to renew your policy?  
☐ Yes ☐ No

16. Has any insurance carrier ever declined professional liability insurance to you?  
☐ Yes ☐ No

17. Has any claim or suit for alleged malpractice ever been brought against you?  
☐ Yes ☐ No

18. Are you aware of any circumstances that might reasonably lead to such a claim or suit?  
☐ Yes ☐ No

NOTE: If you answered yes to question 18, please provide the following information to complete and expedite our underwriting review:

1. a full typewritten narrative, in your own words, of each situation, including a statement of the facts at issue (include names, dates, places, your diagnosis, and treatment of the case).

2. a copy of the petition filed against you, and/or any judgment or settlement if applicable; and

3. a copy of the complete hospital chart, your office records, and a complete copy of all medical records (hospital, ambulatory care, office, etc.) pertinent to the claim;

Please be as thorough as possible in order for the Underwriting Dept. to give your application a prompt review.

19. Name of current professional liability insurance carrier including expiration date, policy number, and limits:

________________________________________________________________________

20. List names of all professional liability insurance carriers that you have been insured with for the last 10 years and dates of coverage:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

21. How many times have you changed your place of practice in the last 10 years, and what were the reasons for the changes?
I hereby declare that all statements and answers herein are full, complete, and true to the best of my knowledge and belief and that no material circumstance or information concerning the subject matter of the questions asked has been withheld or omitted.

I authorize any professional societies, prior or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions or persons that may have any record or knowledge concerning any of the statements and answers made herein to release such information to LAMMICO upon its request. I authorize the use of a copy of this authorization in place of the original.

Signing this application does not bind the company to renew a policy of insurance. However, it is agreed that this form shall be the basis of the policy.

[Signature and date in the space below]