Locum Tenens - Physicians and Surgeons
Application for Professional Liability Insurance

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.

A. Personal Information

Full Name of Locum Tenens (Last, First, Middle)	Suffix ☐ Jr. ☐ Sr. ☐ II ☐ III ☐ IV	Gender ☐ M ☐ F	Name of LAMMICO Insured
Social Security Number	Date of Birth (mm/dd/yyyy)	NPI Number	
Primary Practice Address (include city, state, zip)			Office Phone Number
Practice Name (if any)			Fax Number
Years at Current Practice Location	Other Practice Locations? ☐ Y ☐ N If *yes*, please list in "Remarks" section		
Practice Mailing Address (include city, state, zip)			
Home Address (include city, state, zip)			Home Phone Number
Email Address	Website Address		Cell Phone Number

Desired Coverage Period – while serving in LAMMICO insured's place

FROM: ______ / ______ / ______ (MM DD YYYY) **TO:** ______ / ______ / ______ (MM DD YYYY) ***If multiple periods please describe in Remarks***

B. Specialty Information

1. 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.

2. 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
☐ Acupuncture—other than acupuncture anesthesia
☐ Angiography
☐ Angioplasty
  ☐ Coronary
  ☐ Peripheral

☐ Cryosurgery
  ☐ On benign dermatological lesions
  ☐ Other: ______________________________
☐ Diagnostic sonography
☐ Discograms
☐ Electroshock therapy (psychiatric)
☐ Fiberoptic bronchoscopy
☐ Hair transplant

- ☐ 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
- ☐ Colonoscopy
- ☐ Cosmetic/Aesthetic procedures – specify type in "Remarks"
- ☐ Cosmetic injections—specify type:______________________
- ☐ Cosmetic/reconstructive skin flaps and skin grafts
  - ☐ with arterial blood supply other than cancer therapy
- ☐ Dermabrasion
- ☐ Interventional endoscopy—specify type: _______________
- ☐ Laser therapy—specify type:_________________________
- ☐ Mohs Surgery
- ☐ Myelography
- ☐ Needle biopsy
  - ☐ Lung, liver, kidney or prostate ☐ Breast
  - ☐ Other—specify type: _________________________
- ☐ Nerve blocks, therapeutic—specify type in "Remarks"
- ☐ Pain management—specify type in "Remarks"
- ☐ Pneumatic or mechanical esophageal dilation (not with bougie or olive)
- ☐ Radiopaque contrast material injections into veins, blood vessels, lymphatic, sinus tracts, and fistulae
- ☐ Radiopaque contrast material injections into arteries
- ☐ Radiation therapy
- ☐ Vasectomy
- ☐ Vein procedures – in office only – specify type in "Remarks"
- ☐ Other: ____

Major Surgery & Procedures—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 – specify type: ____
- ☐ Bariatric/Obesity surgery—specify type: ____
- ☐ Bone fractures ☐ Operative treatment ☐ Closed manipulation-general or regional anesthesia
- ☐ Fertility or reproductive surgery ☐ Gender reassignment ☐ Adult ☐ Minor
- ☐ Gynecological procedures ☐ Dilation and currettements other than emergency
- ☐ Laparoscopic Cholecystectomy
- ☐ Laparoscopy ☐ Diagnostic ☐ Sterilization ☐ Therapeutic
- ☐ Liposuction—specify type, and if performed under general or local anesthesia: ________________________
- ☐ Minimal invasive endoscopic surgery—specify type: ____
- ☐ Obstetrical procedures ☐ Cesarean sections ☐ Forceps delivery other than outlet forceps ☐ Abortions
  - ☐ Home Delivery ☐ Vaginal Delivery
  - ☐ Other: ____
  - Abortions: ☐ Elective ☐ Therapeutic
- ☐ Ophthalmology Surgery – (e.g. laser, transplant, cataract, etc.) specify type(s): ________________________
- ☐ Penile implants
- ☐ Percutaneous disc surgery
- ☐ Plastic surgery ☐ Cosmetic—specify type: ______________________ ☐ Breast augmentation/reduction
  - ☐ Reconstructive—specify type: ______________________________________
  - ☐ Facial—specify type: ____
- ☐ Spine surgery ☐ **Primary** ☐ **Reoperative**
  - Primary: ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Spinal instrumentation
  - Reoperative: ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Spinal instrumentation
- ☐ Tonsillectomies and/or adenoidectomies
- ☐ Transplant surgery – specify type: ____
- ☐ Other: ____

C. Licensing Information

1. Medical License Information - please list below:

State	License number	License Expiration Date	License Status

2. 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
   If *yes*, please describe: ____
3. State Narcotics / CDS License #: ____________________ Federal Narcotics / DEA License #: ____________________
   (a) Does your narcotics license include Schedule 1 drugs? If *yes*, please explain in "Remarks". ☐ Yes ☐ No
4. Do you dispense drugs (other than free samples) in your office? ☐ Yes ☐ No
   If *yes*, please list your State Dispensing number: State ____Number___________ and outline your training and record keeping under "Remarks" section.

D. Education / Training Information

Undergraduate School, Location	Degree	Year Graduated
Medical School, Location	Degree	Year Graduated
Served Internship at (PG I)	Specialty	Dates Attended (from – to) ___________-__________
Served Residency at (PG II - ?)	Specialty	Dates Attended (from – to) ___________-__________
Did you successfully complete any residency program? ☐ Yes ☐ No	If *no*, please explain in the "Remarks" section	
Fellowship or Postgraduate Training, Location	Specialty	Dates Attended (from – to) ___________-__________

1. Are you a foreign medical school graduate? ☐ Yes ☐ No (*If you did not obtain a certificate please explain in "Remarks"*)
   (a) Indicate which certification was obtained and year certified: ☐ ECFMG ☐ Fifth Pathway Year Certified: ______________
2. Are you certified by an approved specialty board? (If *yes*, which?) ____________________________________ ☐ Yes ☐ No
   (a) Has there been a change in board status? (If *yes*, explain) _______________________________________ ☐ Yes ☐ No

E. Additional Information

NOTE: If you answer yes to any of the following questions, please give detailed information in the "Remarks" section of this application. (Attach additional sheets if necessary.)

1. Has Medicare/Medicaid brought documented charges against you for alleged fraud or inappropriate fees? ☐ Yes ☐ No
2. Has any hospital or medical staff ever restricted or revoked your privileges or invoked probation? ☐ Yes ☐ No
3. Has your membership in any medical association or society ever been refused, suspended, revoked, voluntarily surrendered or been censured? ☐ Yes ☐ No
4. Have you been treated for alcoholism, narcotic addiction or mental illness? ☐ Yes ☐ No
5. Have you volunteered to or been asked to participate in a physician's health (impaired) program? ☐ Yes ☐ No
6. Have Preceptor(s) or assisting physicians ever been assigned to your practice by a state licensing committee? ☐ Yes ☐ No
7. Have you now or have you ever had a chronic illness or physical limitation that impairs or could tend to impair your ability to practice medicine? ☐ Yes ☐ No
8. Have you been charged with or convicted of a crime (other than a minor traffic violation)? ☐ Yes ☐ No
9. Have fee complaints or professional relations complaints been registered against you with your medical society/association or state licensing authority? ☐ Yes ☐ No

10. Has your professional liability insurance ever been cancelled, non-renewed, restricted or surcharged? ☐ Yes ☐ No
11. Has any insurance carrier ever declined to offer professional liability insurance to you? ☐ Yes ☐ No
12. Has any claim or suit for alleged malpractice ever been brought against you? ☐ Yes ☐ No
    If *yes*, has this been reported to your present or prior insurer(s)? ☐ Yes ☐ No
13. Are you aware of any circumstances that might reasonably lead to a claim or suit? ☐ Yes ☐ No
    If *yes*, has this been reported to your present or prior insurer(s)? ☐ Yes ☐ No

NOTE: If you answered yes to question 12, please provide the following information to complete and expedite our underwriting review:

1. ***For each claim, complete the attached CLAIM ADDENDUM***
2. ***A copy of the petition filed against you, if available***
3. ***If you think it will help in the evaluation of the claim, include 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***

We may ask for additional information as needed. Please be as thorough as possible in order to expedite the review of your application.

Question No.	"Remarks" (Attach additional sheets, if necessary)

Sign and date application in the space below.

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 understand that the statements and answers will be relied upon by LAMMICO and are material in determining not only whether insurance coverage will be issued or renewed, but also correct classification.

I hereby authorize release of my name, address, policy, and premium information by LAMMICO to its agents or designees subject to confidentiality and nondisclosure agreements.

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 issue a policy of insurance. However, it is agreed that this form shall be the basis of the policy.

Applicant Signature____ _______________________

Date (MM/DD/YYYY)

Print Name____

FRAUD NOTICE – WHERE APPLICABLE UNDER THE LAW OF YOUR STATE

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application of insurance is guilty of a crime and may be subject to fines and confinement in prison.