

8. A. List hospitals at which you are currently a staff member and show % of work at each hospital.
1. _____ %
2. _____ %
3. _____ %
- B. Briefly describe type and extent of your hospital privileges:
- _____
- _____
- C. Are you Chief or Head of a hospital department? ___Yes ___No
9. Do you or the firm listed in Question 6.B. above own (wholly or in part) operate, or administer any hospital, nursing home, or other institution where medical services are customarily rendered? ___Yes ___No
If yes, give details, including name, location, size and number of beds.

CURRENT PRACTICE

10. A. What is your medical or surgical specialty? _____
- B. Do you limit your practice to the above specialty? ___Yes___No
- C. Do you have a sub-specialty? ___Yes___No. If yes, describe: _____
- _____
11. Do you perform one or more of the following:
- | | YES | NO |
|--|--------|-------|
| A. Endoscopic Procedures (other than sigmoidoscopy or proctoscopy)?
If "yes", describe below. If you perform any minimal incision surgery, check here _____ | A_____ | _____ |
| B. Catheterization (other than swan-ganz, umbilical cord or urethral catheterization or arterial line in a peripheral vessel? Describe: _____ | B_____ | _____ |
| C. Arteriography/lymphangiography/myelography/phenmoencephalography? | C_____ | _____ |
| D. Interventional radiology-percutaneous transluminal angioplasty or embolization? | D_____ | _____ |
| E. Radiation therapy - deep (includes radium implants)? | E_____ | _____ |
| F. Chemobrasion/dermabrasion/hair transplants or suturing of hairpieces? | F_____ | _____ |
| G. Mohs micrographic surgery? Describe: _____ | G_____ | _____ |
| H. Acupuncture (for analgesia) or Acupuncture anesthesia? Describe: _____ | H_____ | _____ |

YES NO

- I. Prenatal care and normal deliveries? If "yes",
Do you perform home deliveries? __Yes__No
Do you only perform prenatal care? __Yes__No
Do you supervise nurse midwives? __Yes__No, If "yes", indicate when
you refer: ___weeks gestation I ___ NO ___
- J. Dilation and curettage? J ___ NO ___
- K. Needle biopsies? Describe: _____ K ___ NO ___
- L. Electroshock therapy or hypnosis? Describe: _____ L ___ NO ___
- M. Radial keratotomy? Indicate where performed: ___Hospital ___Office
___Surgicenter M ___ NO ___
- N. Hexagonal keratotomy? Indicate where performed ___Hospital ___Office
___Surgicenter N ___ NO ___
12. Do you perform any one or more of the following:
- A. Surgery other than incision of boils and superficial abscesses or suturing
skin and superficial fascia? A ___ NO ___
- B. Non-spontaneous, induced abortions?
___1st trimester(Not exceeding 14 weeks gestation)
___2nd trimester (indicate where performed: ___Hospital ___Office
___Surgicenter B ___ NO ___
- C. Sterilization procedures? Describe: _____ C ___ NO ___
- D. Cosmetic plastic surgery, cosmetic body contouring (Suction lipectomy),
implantations, injections and/or blepharopigmentation? Describe: _____
_____ D ___ NO ___
- E. Spinal surgery. If you also perform chemonucleolysis, check here _____
and/or percutaneous lumbar discectomy, check here _____ E ___ NO ___
- F. Open reduction of fractures? Describe: _____ F ___ NO ___
- G. Administration of general, spinal or caudal block anesthesia? G ___ NO ___
- H. Hysterectomies? Do you perform laparoscopic hysterectomies? H ___ NO ___
- I. Cholecystectomies? Do you perform laparoscopic cholecystectomies?
Indicate number of laparoscopic cholecystectomies performed to date _____ I ___ NO ___
- J. Tonsillectomies and/or Adenoidectomies? J ___ NO ___
- K. Caesarian sections? K ___ NO ___

YES NO

- L. Organ transplantations? Describe: _____ L _____ NO _____
- M. Weight reduction surgery? M _____ NO _____
- N. Sex change operation? Describe: _____ N _____ NO _____
- O. Experimental research or surgical research or experimental therapy in human patients? Describe: _____ O _____ NO _____
- P. Other surgery? Describe: _____ P _____ NO _____
13. A. Do you perform surgery in your office? ___Yes___No, If "yes" list surgical procedures: _____
- B. Do you perform surgery in other non-hospital facilities? ___Yes___No. If "yes", list facilities and surgical procedures: _____
- C. In course of surgery (described in A or B above) is general anesthesia administered? By you? ___Yes___No, By others? ___Yes___No
14. A. Indicate number of hours per month devoted to hospital emergency room care: _____hours per month
- B. Is this emergency room care:
1. On your own patients only? ___Yes___No
 2. Required for staff privileges ___Yes___No
 3. Other _____Yes___No
15. Do you assist in surgery: On your own patients? ___Yes___No. Patients of others? ___Yes___No
16. If your practice includes plastic surgery, specify percent of practice devoted to traumatic surgery ___%; cosmetic surgery ___%
17. Do you practice weight reduction or control (other than by diet-exercise)? ___Yes, ___No, if "yes", percent of patients exclusively weight control ___% Do you dispense (as opposed to prescribe) any weight control drugs? ___Yes, ___No. If "yes", list drugs dispensed _____
- Do you use injections for weight control? ___Yes___No. If "yes" list drugs injected: _____
18. Do you participate in any activity, e. g. newspaper columns, broadcasts, etc., whereby professional advice is offered to the public? ___Yes___No. If "yes", please attach detailed explanation of this activity.
19. A. List number and type of professional employees: IF NONE, STATE NONE.
_____Physicians (other than yourself) _____Surgeon's Assistants*
_____Nurse Practitioners*/Physician 's Assistants*
_____Nurse Anesthetists _____Other (describe) _____

* Describe duties in detail, including extent supervised, on separate sheet

B. Are all of the above individuals licensed in accordance with applicable state and federal regulations?
 ___ Yes ___ No. If "no" attach explanation.

20. Have you or any of the above employees: (Attach detailed explanation for any "yes" answers)

- | | YES | NO |
|---|-------|-----|
| A. Ever been the subject of investigative or disciplinary proceedings or reprimand by a governmental or administrative agency, hospital or professional association? (Attach copy of Complaint and Consent Order documents, if applicable.) | A ___ | ___ |
| B. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? | B ___ | ___ |
| C. Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required you be evaluated for an alleged mental condition and/or alcohol or drug addiction? | C ___ | ___ |
| D. Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? | D ___ | ___ |
| E. Ever had any professional liability insurance cancelled,declined, refused to renew or accepted only on special terms? | E ___ | ___ |
| F. Ever failed any medical licensing or specialty organization examination? | F ___ | ___ |
| G. Do you have any chronic physician illness or defect? | G ___ | ___ |

21. Do you supervise any individuals other than your own employees? ___ Yes ___ No. If "yes", provide detailed explanation of responsibilities and relationship to the entity which employs these individuals. Also, indicate by profession the number of individuals supervised.

NUMBER	TYPE OF PROFESSION	NUMBER	TYPE OF PROFESSION
_____	Physicians	_____	_____
_____	X-Ray Technicians	_____	_____
_____	Laboratory Technicians	_____	_____

22. Are you in the employ of any individual, firm or corporation other than your own? ___ Yes ___ No. If "yes", attach explanation, including details of any responsibilities.

23. Are you under contract to any individual, firm or corporation other than your own? ___ Yes ___ No. If "yes", attach explanation including details of your responsibilities. If this contract contains a hold-harmless agreement copy of contract must be attached to the application.

24. Are you in the employ of or under contract to any governmental entity? ___ Yes ___ No. If "yes", attach explanation, including details of your responsibilities.

33. Do you practice in a surgicenter, abortion clinic, drug control clinic, emergi-center, extended hr. walk-in clinic or birthing center? ___Yes___No If "yes" state location and describe_____

34. A. Average patient load:_____Patients Weekly _____Total Patients Annually

B. Average number of hours practice time:_____Hours weekly

35. Do you anticipate changes in your practice in the next 12 months?___Yes ___No., If "yes", explain_____

36. Approximate gross annual income from the practice (check one):
 _____Less than \$50,000. _____\$100,000 - \$199,999 _____\$200,000 or more (please estimate)
 _____\$50,000 - \$99,999. _____\$150,000 - \$199,999

37. A. List prior professional liability insurance carried to each of the past five years. IF NONE, Check Here_____.

INSURANCE COMPANY	LIMITS OF LIABILITY	PREMIUM	INCEPTION MO/DAY/YR	EXPIRATION MO/DAY/YR	RETROACTIVE DATE MO/DAY/YR	WAS THIS A CLAIMS MADE POLICY FORM?	
						YES	NO
1. _____	_____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____	_____

B. ATTACH A COPY OF THE DECLARATIONS PAGE FROM YOUR MOST RECENT COVERAGE.

WARRANTY: It is warranted to Admiral Insurance Company that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Company evidence its acceptance of the application by issuance of a policy. I/We hereby authorize the release of claim information from any prior insurer to Admiral Insurance Company.

PLEASE REVIEW THE POLICY CAREFULLY. Except to such extent as may be provided otherwise in the policy, the policy for which application is being made is limited to ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED while the policy is in force.

Signature of Applicant* _____ Date _____
 One signed copy will be attached to the policy, cover note or certificate, if issued

*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.