



## PHYSICIANS AND PSYCHIATRISTS SUPPLEMENT

**INSTRUCTIONS:** Please complete the entire form. If a section does not apply answer "n/a" or "none". Information provided by you will be used by underwriters in determining the acceptability of adding you to the Clinic/Center's professional liability insurance coverage.

Your Name \_\_\_\_\_ Clinic/Center Name \_\_\_\_\_

Medical Specialty \_\_\_\_\_

Are you Board Certified? Yes  No  If No, are you Board Eligible? Yes  No

License Number/State \_\_\_\_\_

What is your working relationship with the Clinic/Center? Employee  Contractor  Volunteer

Hours per week you work on behalf of the Clinic/Center? \_\_\_\_\_

7. Do you practice medicine outside your work for this Clinic/Center? Yes  No

List the responsibilities/duties you perform for the Clinic/Center (please be specific).

\_\_\_\_\_

\_\_\_\_\_

Do you or will you perform any of the following medical procedures or services on behalf of the Clinic/Center?

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Intake Interviews/Bio-Psych-Soc	<input type="checkbox"/>	<input type="checkbox"/>	Electroshock Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Physical Exams	<input type="checkbox"/>	<input type="checkbox"/>	Invasive Diagnostic Tests	<input type="checkbox"/>	<input type="checkbox"/>
Medical Detox	<input type="checkbox"/>	<input type="checkbox"/>	Prescribe Medicines	<input type="checkbox"/>	<input type="checkbox"/>
Rapid Detox	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Methadone/Bup/Naltrexone	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS Treatment	<input type="checkbox"/>	<input type="checkbox"/>

**PLEASE PROVIDE EXPLANATION OF ANY "YES" ANSWERS TO THE FOLLOWING QUESTIONS ON THE BACK OF THIS PAGE OR ON A SEPARATE SHEET OF PAPER:**

Have you ever had a malpractice claim or suit filed against you? YES NO

Have you ever had your medical license revoked, suspended, restricted or placed on probation? YES NO

Have you ever been the subject of an investigation, disciplinary proceeding or reprimand? YES NO

Have you ever been convicted of a crime or felony? YES NO

Have you even been treated for alcoholism or drug addiction? YES NO

Provide information on your currently in-force malpractice insurance. (if none exists, please indicate "none")

a. Insurance Company Name \_\_\_\_\_ Expiration Date \_\_\_\_\_

b. Limits of Liability \$ \_\_\_\_\_ Retro Date \_\_\_\_\_

c. Does your current malpractice policy extend to cover you for your acts at the Clinic/Center? YES NO

\_\_\_\_\_  
Physician/Psychiatrist Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

NOTE: by signing and dating the above, you are warranting the answers above are true and accurate to the best of your knowledge.

### Addiction Treatment Providers Insurance Program

A Division of NSM Insurance Group  
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