



Anesthesiologists' Professional Assurance Company

**TO BE COMPLETED BY PHYSICIAN'S ASSISTANT**

*(All statements below must be completed and all questions answered completely)*

**DO NOT CANCEL YOUR PRESENT INSURANCE UNTIL A BINDER LETTER HAS BEEN RECEIVED.**

1. Name \_\_\_\_\_ Phone No. (\_\_\_\_) \_\_\_\_\_
2. Name of Physician to whom certified \_\_\_\_\_
3. His/her Policy No. with the Company \_\_\_\_\_
4. Mailing Address \_\_\_\_\_  
Address of Physician to Whom Certified
5. I request an effective date of 12:01 A.M. \_\_\_\_\_, 20 \_\_\_\_\_
6. What date were you certified to your present physician? \_\_\_\_\_
7. Date employed \_\_\_\_\_ Florida Certificate # \_\_\_\_\_ Date Issued \_\_\_\_\_
8. Were you previously certified to a physician in the state for which you want coverage?  
\_\_\_\_\_ YES \_\_\_\_\_ NO

If **Yes**, complete the following:

Name of Physician	Address	Dates
_____	_____	_____
_____	_____	_____

9. What is the name of your last professional liability insurer, policy number and expiration date?  
 \_\_\_\_\_
10. Have you ever been involved in a malpractice claim or suit, either directly or indirectly? \_\_\_\_\_  
**(Complete supplementary claims information form on each claim or suit.)**
11. Have you ever had Professional Liability Insurance refused, declined, cancelled or accepted on special terms? \_\_\_\_\_  
 If **Yes**, give details \_\_\_\_\_
12. The foregoing answers and statements are complete and correct to the best of my knowledge and belief.

**Furthermore, I am attaching a copy of the applications for certification completed by the physician to whom I am certified, myself as physician's assistant and a copy of the certificate issued by the State in which I practice.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Physician's Assistant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Physician to Whom Certified

## SUPPLEMENTARY CLAIMS INFORMATION

Please use separate form for each claim, if there has been more than one claim.

**IMPORTANT:** The word "claim" as used in question #10 refers to:

1. Any suit or claim, settled or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate or employee, or
2. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you.

Complete information is necessary to avoid possible complications under your insurance policy issued in reliance upon this application.

PATIENT'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

DATE OF INCIDENT AND YOUR TREATMENT \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

ALLEGATIONS \_\_\_\_\_

\_\_\_\_\_

PRESENT STATUS OF CLAIM: (check applicable answer)

- |  |   |
|--|---|
| <input type="checkbox"/> 1. Suit threatened, no action taken | <input type="checkbox"/> 5. Court trial in your favor                         |
| <input type="checkbox"/> 2. Dropped by claimant              | <input type="checkbox"/> 6. Out of court settlement in the amount of \$ _____ |
| <input type="checkbox"/> 3. Awaiting court action            | <input type="checkbox"/> 7. Court settlement in the amount of \$ _____        |
| <input type="checkbox"/> 4. Summary judgment in your favor   | <input type="checkbox"/> 8. Waiting for mediation                             |

AT THE TIME OF CLAIM, YOUR INSURANCE COMPANY WAS \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_

ATTORNEY WHO REPRESENTED YOU AND HIS ADDRESS \_\_\_\_\_

\_\_\_\_\_

**THE ABOVE IS A TRUE AND CORRECT STATEMENT AND BY SIGNING THIS FORM, I HEREBY AUTHORIZE MY PRIOR INSURANCE COMPANY TO RELEASE ANY CLAIM INFORMATION REQUESTED BY THE FPIC.**

Date \_\_\_\_\_ Signature \_\_\_\_\_

*(A photostatic copy of this authorization shall be considered as effective and valid as the original.)*

*(All statements below must be completed and all questions answered completely)*

**TO BE COMPLETED BY PHYSICIAN'S ASSISTANT**

Name in Full \_\_\_\_\_

Office Address \_\_\_\_\_

Residence Address \_\_\_\_\_

Birth place \_\_\_\_\_ Birth date \_\_\_\_\_ Citizenship \_\_\_\_\_

EDUCATION (give location, dates of attendance and number of years at each school)

High School \_\_\_\_\_

\_\_\_\_\_

Other Training \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PREVIOUS OCCUPATIONS. (Give full name and address of employers, dates and duties of employment. Attach supplemental sheet if necessary.)

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\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If any of the following questions are answered **YES** give full details on a separate sheet of paper and attach to application. **ALL QUESTIONS MUST BE ANSWERED.**

1. Have you ever been convicted of a felony? \_\_\_\_\_ A misdemeanor? \_\_\_\_\_

2. Are you now or have you ever been addicted to the use of narcotics? \_\_\_\_\_

Have you ever been charged with addiction? \_\_\_\_\_

3. Have you ever been addicted to the use of barbiturates or any other medication? \_\_\_\_\_

Have you ever been charged with addiction? \_\_\_\_\_

4. Have you ever engaged in excessive use of alcohol or received treatment for alcoholism? \_\_\_\_\_
5. Have you ever been adjudged mentally incompetent or been voluntarily committed to a mental institution? \_\_\_\_\_

The foregoing answers and statements are complete and correct to the best of my knowledge and belief.

\_\_\_\_\_  
Signature of Physician's Assistant

### TO BE COMPLETED BY PHYSICIAN

*(All statements below must be completed and all questions answered completely.)*

#### PHYSICIAN INFORMATION

1. Name \_\_\_\_\_ Phone No. (\_\_\_\_) \_\_\_\_\_
2. Office Address(es) \_\_\_\_\_  
\_\_\_\_\_
3. Type of Practice \_\_\_\_\_
4. Board Certification \_\_\_\_\_
5. Florida Medical License Number \_\_\_\_\_ Date Issued \_\_\_\_\_

#### PHYSICIAN'S ASSISTANT INFORMATION

6. Name \_\_\_\_\_ Age \_\_\_\_\_
7. Present Address \_\_\_\_\_
8. Graduated from \_\_\_\_\_  
Date Graduated \_\_\_\_\_
9. Other Medical Training or Experience (give dates) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### PRACTICAL UTILIZATION

Name(s) and address(es) of any other physician(s) who will serve as "responsible" physician for the above named Physician's Assistant:

10. Name \_\_\_\_\_ Phone No. (\_\_\_\_) \_\_\_\_\_
11. Office Address(es) \_\_\_\_\_  
\_\_\_\_\_
12. Type of Practice \_\_\_\_\_

13. Board Certification \_\_\_\_\_

14. Florida Medical License Number \_\_\_\_\_ Date Issued \_\_\_\_\_

15. Describe role, activities and functions to be performed by the Physician's Assistant in your office.

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16. Describe role, activities and functions to be performed by the Physician's Assistant in the hospital setting.

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17. Describe role, activities and functions to be performed by the Physician's Assistant in other practice setting.

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18. Describe in detail the acts, tasks and functions that the Physician's Assistant will be allowed to perform under your indirect supervision (i.e. away from your presence), and the safeguards (standing orders, backup arrangements, access via telephone, etc.) which you have established for the protection of the patient.

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19. The foregoing answers and statements are complete and correct to the best of my knowledge and belief.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Physician