Anesthesiologists' Professional Assurance Company

TO BE COMPLETED BY NURSE ANESTHETIST

(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 Employer ____
3. Mailing Address ____
   (Address of Employer)
4. I request an effective date of 12:01 A.M. ______________________, 20 ______________
5. Active RN License No. ______________________________ Date Issued ____________
6.. ARNP/Nurse Anesthetist License No. ______________________ Date Issued ____________
7. Date employed __________ Birth date __________ Birth place ______________________
8. EDUCATION
   (a) RN Training:
   ____
   Name of Hospital City & State Dates: From To
   (b) Anesthesia Training:
   ____
   Where What Type Dates: From To
   (b) Additional Training:
   ____
   Where What Type Dates: From To
9. What is the name of your last professional liability insuror, 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. PREVIOUS WORK EXPERIENCE
    Employer Address Dates Employed
    ____
    ____
12. The foregoing answers and statements are complete and correct to the best of my knowledge and belief.

______________________ ________________________________
Date Signature of Nurse Anesthetist

______________________ ________________________________
Date Signature of Employer

FPIC-28 (3/04)

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 #9 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 and fill in amounts where needed**)

- ☐ Precautionary/Incident report only
  Reserve Amount $ ____________
- ☐ Suit threatened, no action
  Reserve Amount $ ____________
- ☐ Dropped by claimant
- ☐ Summary judgment in your favor
- ☐ Court trial in your favor

- ☐ Out of court settlement:
  Date Paid ___________ (mm/dd/yy) Amount Paid $___________
- ☐ Court settlement:
  Date Paid ___________ (mm/dd/yy) Amount Paid $___________

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 FLORIDA PHYSICIANS INSURANCE COMPANY.

Date ______________________ Signature ______________________________

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