



Select Specialty Managers, LLC
a W.R. Berkley Company

EMS Medical Director Renewal Application Checklist

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR APPLICATION:

1. COPIES OF ALL EMS *NEW* MEDICAL DIRECTOR CONTRACTS WITH MUNICIPALITIES OR OTHER ENTITIES INTENDED FOR COVERAGE, IF AVAILABLE
2. PROOF OF MEDICAL MALPRACTICE INSURANCE IF THE APPLICANT ALSO IS A PRACTICING PHYSICIAN*
3. EMS DIRECTOR JOB DESCRIPTION
4. LICENSE NUMBERS FOR ALL STATES IN WHICH APPLICANT IS LICENSED TO PRACTICE MEDICINE

***Note:** The coverage for which you are applying is **NOT** intended to replace standard Medical Malpractice Insurance if you are a physician in private practice or are employed as a physician in addition to your duties as an EMS Medical Director. Please read the policy carefully.



RENEWAL APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

Emergency Medical Services – Medical Directors

THE COVERAGE IS ON A CLAIMS MADE AND REPORTED BASIS.
PLEASE READ THE COVERAGE CAREFULLY.

(PLEASE TYPE OR PRINT IN INK)

1. Applicant's Name: _____
First Middle Initial Last DBA

Address: _____ Home Office

City State Zip Code

Phone: _____ Fax: _____

Email: _____ Website: _____

2. Applicant is:
 Individual Corporation Professional Association Other: _____

3. Limits of Liability desired for Professional Liability:
 \$100,000/\$300,000 \$200,000/\$600,000 \$250,000/\$750,000
 \$500,000/\$1,500,000 \$1,000,000/\$1,000,000 \$1,000,000/\$3,000,000
 Other: _____

4. Is the applicant a licensed physician in Good Standing? Yes No

License #	State	Expiration Date	% Of practice in this state	

5. List the states where the applicant is an EMS Medical Director: _____

6. Are you a State or regional EMS Medical Director? Yes No
If "Yes," please submit a copy of your EMS Medical Director contract/job description.

7. Are you a Medical Reserve Corps (MRC) EMS Medical Director? Yes No
If "Yes," please submit a copy of your MRC EMS Medical Director contract/job description.



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8. Are you employed outside of your duties as an EMS Medical Director? Yes No
- A. If "Yes," check the appropriate boxes: Hospital Emergency Department Urgent Care Facility
 Faculty Other: _____
- B. Duties: _____
 Full-Time Part-Time
- C. Do you carry Physician's Medical Malpractice Insurance for the above duties? Yes No
If Yes, attach a copy of the certificate of insurance or indicate if coverage/indemnification is provided to you by your employer.
NOTE: If you are a general/family practice physician, proof of insurance is required.
If "No," please provide an explanation.
- NOTE: The rendering of medical services outside your capacity as an EMS Medical Director is specifically excluded from coverage for which you are applying.**
9. Do you have Allied Healthcare Personnel in your employment? Yes No
If "Yes," have each of your employed Allied Health Personnel complete an Employee Supplement and attach a copy of licensure and certification for each.
10. Complete the following for each separate contract or entity for which coverage is desired. Check here if no change from prior policy year.



**EMERGENCY MEDICAL SERVICES MEDICAL DIRECTORS PROFESSIONAL
LIABILITY
Physicians Assistant/Employee Supplement
(Attach a resume or CV and copies of licenses)**

1. Applicant's Name: _____

Address: _____ DBA Home Office

City _____ State _____ Zip Code _____

Phone: _____ Fax: _____

Email: _____ Website: _____

2. Have you:
- 2a. Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? Yes No
 - 2b. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No
 - 2c. Ever been treated for alcoholism or drug addiction? Yes No
 - 2d. 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? Yes No
 - 2e. Ever had any insurance company cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? (not allowed in MO) Yes No
 - 2f. Ever had your hospital privileges denied, modified, suspended, revoked, non-renewed or accepted on a restricted basis or been subjected to probation, reprimand, censure, sanction or other disciplinary action as a result of a hospital committee investigation or inquiry? Yes No
 - 2g. Had any malpractice claim or suit brought against you within the past ten (10) years? **If "Yes," please complete the Claim/Circumstance/Administrative Hearings Supplement for each claim/suit brought against you in the past and submit complete copies of all office/hospital records, summons and complaint, etc.** Yes No
 - 2h. Had any professional liability and/or Employment Practices Liability claims or incidents made against you, the applicant, or anyone proposed for this insurance? Yes No
If "Yes," how many? _____
If "Yes," please complete a Claim/Circumstance/Administrative Hearings Supplement for each incident.



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Signature of Employee

Date

Print Name