



EMS Medical Director Application Checklist

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR APPLICATION:

1. COPIES OF ALL EMS 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. CURRENT CURRICULUM VITAE
4. EMS DIRECTOR JOB DESCRIPTION
5. MEDICAL LICENSES



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

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.

If you have a Curriculum Vitae (C.V.), please attach to application and check here:

(PLEASE TYPE OR PRINT IN INK)

ACEP # (if applicable) _____

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

Address: _____ Home Office

City State Zip Code

Phone: _____ Fax: _____

Email: _____ Website: _____

2. Social Security #: _____ Tax ID: _____

3. Date of Birth: _____ Male Female

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

5. 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: _____

6. A. Effective Date Desired _____ 6B. Retroactive Date Desired: _____

7. Is the applicant a licensed physician in Good Standing? Provide copies of all licenses. Yes No

7a. If "Yes," where? _____

7b. If "No," please explain: _____

8. Practitioner DEA Number: _____

9. Medical Specialty Information:
9a. Principal Medical Specialty in which you practice: _____ 9b. % of practice time: _____
9c. Sub-Specialty in which you practice: _____ 9d. % of practice time: _____
9e. Currently Held Board Certifications and Dates: _____
9f. Medical School and Year Graduated: _____
9g. Residency Information/Additional Training: _____
Name of Hospital/Facility: _____ Name of Hospital/Facility: _____



Select Specialty Managers, LLC
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Name

City State Zip Code

Specialty: _____

From: _____ To: _____
mo./yr. mo./yr.

Completed: Yes No

Name

City State Zip Code

Specialty: _____

From: _____ To: _____
mo./yr. mo./yr.

Completed: Yes No

9h. Fellowship Training: _____

10. Have you completed an EMS fellowship? Yes No
If "Yes," please describe: _____

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

12. Date you first became an EMS Medical Director: _____

13. 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.

14. Are you employed outside of your duties as an EMS Medical Director? Yes No
14a. If "Yes," check the appropriate boxes: Hospital Emergency Department Urgent Care Facility
 Faculty Other: _____

14b. Duties: _____
 Full-Time Part-Time

14c. Do you carry Physician's Medical Malpractice Insurance for the above duties? Yes No
If Yes, attach a copy of the certificate of insurance.
If "No," please provide an explanation.

15. Do you currently carry insurance as an EMS Medical Director? Yes No
If "Yes," please provide a copy of your policy declarations.

16. Have you:
- 16a. Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? Yes No
 - 16b. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No
 - 16c. Ever been treated for alcoholism or drug addiction? Yes No
 - 16d. 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
 - 16e. 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
 - 16f. 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
 - 16g. 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



SIGNATURE SECTION AND OTHER INFORMATION

NOTE: Please recheck all answers and sign below. Coverage cannot be bound without signature or if this application is incomplete.

THE UNDERSIGNED REPRESENTS TO THE BEST OF HIS OR HER BELIEF AND KNOWLEDGE, AFTER REASONABLE INQUIRY AND DUE DILIGENCE, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY SUPPLEMENTS THERETO ARE TRUE AND CORRECT.

THE UNDERSIGNED DECLARES THAT ANY CLAIM, INCIDENT OR CIRCUMSTANCE TAKING PLACE PRIOR TO THE EFFECTIVE DATE OF THE INSURANCE APPLIED FOR WILL IMMEDIATELY BE REPORTED IN WRITING TO THE INSURER. AS A RESULT, THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE THE INSURANCE, NOR DOES THE REVIEW OF THIS APPLICATION BIND THE INSURANCE COMPANY TO ISSUE A POLICY.

THE APPLICANT UNDERSTANDS AND AGREES THIS APPLICATION AND ANY SUPPLEMENTS THERETO SHALL BE INCORPORATED INTO ANY POLICY THAT MAY ISSUED AND THE UNDERWRITERS ARE RELYING ON THE TRUTH OF THE STATEMENTS SET FORTH HEREIN IN MAKING A DETERMINATION TO ISSUE ANY POLICY. THE APPLICANT ALSO UNDERSTANDS AND AGREES THIS APPLICATION FOR COVERAGE DOES NOT MEAN ANY REQUESTED COVERAGES, LIMITS OR DEDUCTIBLES SHALL BE GRANTED IN FACT; UNDERWRITERS MUST AGREE TO ANY REQUESTS WHETHER IN THE APPLICATION OR OTHERWISE.

THE UNDERSIGNED INDIVIDUAL REPRESENTS HE OR SHE IS DULY AUTHORIZED AND EMPOWERED TO MAKE THIS APPLICATION, INCLUDING THE REPRESENTATION, ON BEHALF OF THE APPLICANT OR ANY INDIVIDUAL WHO MAY SEEK COVERAGE UNDER ANY BINDER OR INSURANCE POLICY ISSUED IN RELIANCE HEREON.

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FRAUD WARNING (Applicable in Tennessee and Washington): IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

APPLICABLE IN THE STATE OF NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONTAINING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Signature and Title of Principal (must be owner, partner, or officer)

Date

Print Name and Title of Principal Signing Above



**EMERGENCY MEDICAL SERVICES MEDICAL DIRECTORS PROFESSIONAL
LIABILITY CLAIM/CIRCUMSTANCE/ADMINISTRATIVE HEARINGS
SUPPLEMENT**

APPLICANTS INSTRUCTIONS:

- Complete one form for each claim or circumstance reported in the last ten (10) years involving you or your medical license.
- If space is insufficient to answer any question, use the reverse side or attach a separate sheet.
- Answer all questions.

(PLEASE TYPE OR PRINT)

1. Name(s) of individual(s) in the company named in the claim: _____

2. Name of claimant: _____

3. To what insurance company did you report this claim or incident? _____

3a. Date of alleged error: _____

3b. Date reported: _____

3b. Date first notice received: _____

4. Present status of claim (check one): in suit open circumstance closed

4a. If closed:

i. Total damages paid: \$ _____

ii. What is your percentage of the total settlement of all parties involved in this claim? _____ %

Total defense costs paid (including any deductible paid), if known:

\$ _____

Indicate whether: court judgment out of court settlement.

4b. If in suit or open: (Complete if known)

Amount asked in summons: \$ _____

Claimant's settlement demand: \$ _____

Defendant's offer for settlement: \$ _____

Insurer's loss reserve*: \$ _____

Defense costs paid to date: \$ _____

Your deductible that will apply to this claim: \$ _____

5. Description of claim (provide enough information to allow evaluation and attach a separate page if additional space is required). Alleged act, error or omission upon which claimant bases claim:
