

BERKLEY SELECT LLC

EMS Medical Director Application Checklist

PLEASE INCLUDE THE FOLLOWING INFORMATION WITH YOUR APPLICATION:

1. PROOF OF MEDICAL MALPRACTICE INSURANCE IF THE APPLICANT ALSO IS A PRACTICING PHYSICIAN*
2. CURRENT CURRICULUM VITAE
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.

Complete ALL areas of the application, indicating “N/A” when necessary.

Return the completed application to:

Lapre Scali & Company Insurance Services, LLC
c/o Thomas James
6200 Coors Blvd NW #K-3
Albuquerque NM 87120
Phone: 1-505-899-2068 or 1-866-577-7833
Fax: 1-505-217-0570
Email: tjames@laprescali.com

BERKLEY SELECT LLC

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)

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.

License #	State	Expiration Date	% Of practice in this state

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: _____

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 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.

15. Are you employed outside of your duties as an EMS Medical Director? Yes No

15.a. If "Yes," check the appropriate

boxes:

Hospital Emergency Department Urgent Care Facility
 Faculty Other: _____

15.b. Duties: _____

Full-Time Part-Time

15.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.

16. Do you currently carry insurance as an EMS Medical Director? Yes No

If "Yes," please provide a copy of your policy declarations.

17. Have you:

17a. Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? Yes No

17b. Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No

17c. Ever been treated for alcoholism or drug addiction? Yes No

17d. 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

17e. 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

- 17f. 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
- 17g. 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
- 17h. 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.
- 17i. Been made aware of any facts or circumstances, which might give rise to a medical malpractice, professional liability or Employment Practices Liability claim or complaint? Yes No
 If "Yes," how many? _____
 If "Yes," please complete a Claim/Circumstance/Administrative Hearings Supplement for each incident.
- 17j. Been made aware of any charges, inquiries, investigations, grievances or other administrative or disciplinary hearings? Yes No
 If "Yes," how many? _____
 If "Yes," please complete a Claim/Circumstance/Administrative Hearings Supplement for each incident.

18. 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.

19. Complete the following for each separate contract or entity for which coverage is desired.

Medical Director Contracts: Name Each Entity	Type of Entity: P=Public V=Private	Contract in place Y/N	Cities/ Counties Served	No. of EMTs/ Paramedics under your Direct Supervision	No. of Emergency Calls (Annually)	No. of Non-Emergency Calls (Annually)	Revenue Salary for Each Contract	E=Employee IC=Independent Contractor

20. Define the services you provide under the above contracts. Provide a job description or copies of contracts, if available.

21. I certify that I am a licensed physician in good standing. Yes No

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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:

