



Application

For

Nurse Midwives

Professional Liability Insurance

**PROFESSIONAL LIABILITY POLICY APPLICATION
TO: PHYSICIANS' RECIPROCAL INSURERS, AN Exchange**

APPLICATION FOR NURSE MIDWIVES

* Please note: Coverage is available on an Occurrence Basis only for Nurse Midwives

If my application is approved, make coverage effective on _____ if possible, otherwise on any other date set by the Exchange.

1. Applicant's Full Name: _____

a) Home Address: _____

b) Home Phone Number: _____

c) Name of Employer: _____

d) Address of Employer: _____

e) Employer Practices as: _____ Individual Practitioner
_____ Partnership _____ Professional Corporation

f) Name and Specialty of Supervising Physician:

Name	Specialty

2. Social Security Number: _____

3. Date of Birth: _____

4. Professional Education

a. Name(s) and Address(es) of Nursing School:

Date of Graduation: _____

b. Type(s) of Degrees, Diplomas, Certifications Received and Dates Acquired:

c. Name and Address of Nurse-Midwifery Training School:

d. Type(s) of Degrees, Diplomas, Certifications Received and Dates Acquired:

5. Licensing

a. Current Nursing License Number: _____

_____ State

_____ Expiration Date

b. Are you New York State Certified to practice nurse-midwifery?

_____ Yes _____ No

6. List all Continuing Education Units (CEUs) obtained in the last five years:

7. Are you certified by the American College of Nurse Midwives?

_____ Yes _____ No

If no, please explain: _____

If yes, Certification Number: _____

* Please attach a copy of certification with application.

Are you a current member in good standing of the American College of Nurse-Midwives?

_____ Yes _____ No

If no, please explain: _____

8. a. What is the average number of hours per week you work as a nurse midwife? _____
 b. What is your patient load per week? _____
 c. How many hours per week are you on call? _____

9. a. Is your practice _____ OB/GYN _____ GYN Only
 Describe your practice: _____

Does your employment/practice require that you ever be in an operating room?

_____ Yes _____ No

If yes, do you _____ Observe _____ Assist _____ Second Assist _____ Other

If other, please describe _____

10. Are you associated with a: _____ Hospital _____ Birthing Center
 _____ Other (explain) _____

Name and Address: _____

Birthing Center License No. _____

Are you an employee? _____ Yes _____ No

If no, please explain the nature of your privileges:

11. a. If your practice is OB/GYN, how many deliveries do you perform per year?

b. What percentages of your deliveries are routinely done in each of the following (must total 100%).

_____ % Hospital _____ % Birthing Center _____ % Home

_____ % Other, please describe: _____

c. Which method of natural childbirth do you practice? _____

d. Do you participate in the performance of Cesarean sections as part of your practice?

_____ Yes _____ No

If yes, specify in what capacity: _____

12. Of your total practice, what percentage of time is spent for the following (must total 100%):

_____ % Antepartum Care _____ % Well Women Gynecology _____ % Administrative

_____ % Intrapartum Care _____ % Postpartum Care _____ % Family Planning

_____ % Other, specify: _____

13. Has any claim or suit for alleged malpractice ever been brought against you, or are you aware of any circumstances that might reasonably lead to such a claim or suit?

_____ Yes _____ No

If yes, on a separate sheet, please provide complete details of each incident, including date, disposition, dollar amount of claims, and allegations (see page No. 6).

14. a. Have you ever appeared before a state regulatory or review committee for alleged misconduct or malpractice? _____ Yes _____ No

b. Has your license to practice nursing and/or nurse-midwifery ever been revoked, suspended or subjected to probation? _____ Yes _____ No

c. Has your membership in any nursing/medical/professional association ever been refused, suspended, revoked or voluntarily surrendered? _____ Yes _____ No

d. Has any clinic, hospital, or birthing center, etc., ever suspended, restricted, or revoked your privileges? _____ Yes _____ No

e. Have you ever been convicted of any criminal charge? _____ Yes _____ No

If you answered YES to any of the above, please explain on a separate sheet of paper.

15. Current Insurance Coverage

a. Insurance Carrier: _____

b. Limits of Liability: _____

- c. Policy Effective and Expiration Dates: _____
- d. _____ Deductible _____ Self-insured Retention Amount \$ _____
- e. Coverage Type: _____ Occurrence _____ Claims-Made
- Prior Acts Date: _____
- f. Desired Effective Date of Coverage: _____

Enclose a copy of your current Declarations page (this page contains your name, address, insurance company's name and address, policy number and effective date, etc.).

16. Has your professional liability insurance ever been cancelled or non-renewed?

_____ Yes _____ No

If yes, please explain: _____

17. a. Do you have a contract or consultation/collaborative agreement with a licensed practicing obstetrician? _____ Yes _____ No

b. Do you have a contract or consultation/collaborative agreement with a licensed practicing family practitioner? _____ Yes _____ No

c. Do you have documentation of the Informed Consent process according to ACNM standards? _____ Yes _____ No

d. Do you have written protocols that address the management of clinical issues, the management of emergency clinical issues, including transfer to physician?

_____ Yes _____ No

e. When the patient's medical status changes from low risk pregnancy, do you have written plans that address: (1) the transfer of care to a physician; (2) notification of request for a medical consult; and (3) documentation of the process?

_____ Yes _____ No

IF YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE SUBMIT WITH THIS APPLICATION.

18. Is an EFM strip used to monitor every patient at the beginning of the evaluation of active labor (Baseline monitor strip)? _____ Yes _____ No

19. Do you maintain a current CPR certification for resuscitating both adult and neonatal patients? _____ Yes _____ No

Please make additional photocopies for each additional claim.

Claim Information

1. Name of patient: _____ 2. Age: _____ 3. Sex: _____

4. Allegation and your relationship to patient (e.g.: attending physician, primary surgeon, asst. surgeon, etc.).

5. Date of incident: _____ 6. Location: _____

7. Insurance carrier: _____

8. Other defendants: _____

9. Present status: Open Claim _____

Closed Claim _____ Loss: \$ _____

Date Closed: _____ Settlement: _____

Judgement: _____

10. Condition and diagnosis at time of incident: _____

11. Dates and description of treatment rendered: _____

12. Condition of patient subsequent to treatment and DATES of FOLLOW-UP TREATMENT:

I HEREBY DECLARE the above information is complete and true to the best of my knowledge and belief.

Signed: _____ Date: _____

I do hereby warrant the truth of any statements and answers mentioned herein, and that I have not misrepresented or withheld any information which is calculated to influence the judgement of the Exchange in considering this application for professional liability insurance.

AGREEMENT: I understand that the policy being applied for does not cover liability of others which I may have assumed under any contract or agreement. To assure proper protection I agree to submit a copy of such contract or agreement to the Exchange for underwriting consideration together with this application.

The application form duly completed, together with any supplementary information, must be signed in ink by the applicant. Signature of the form does not bind the applicant or the Exchange to issue coverage.

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 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 _____ Date _____
(APPLICANT'S SIGNATURE)

I understand that in order to underwrite professional liability insurance, The Exchange must have access to all possible information concerning my personal and professional life. I hereby authorize and direct any medical society, medical doctor, hospital, residency program, insurance company, underwriter, and insurance agent to furnish any information concerning me or my medical practice which the company may request.

Since I understand that free exchange of information is essential, I agree that any person or organization furnishing information to the Exchange pursuant to this consent and direction, together with the agents, employees, or officers of such person or organization will not be liable to me in any way for furnishing such information, even though information is wrong.

I understand and agree that, if I am approved as a Subscriber to the Exchange and a policy is issued to me, that there is a continuing obligation on my part to update and keep current all of the information furnished by me as part of this application.

Signature _____ Date _____
(APPLICANT'S SIGNATURE)

To be signed by the nurse midwife's supervising physician before insurance can be effected.

Certificate Required for **Certified Nurse Midwife** Applicant

I understand that:

- PRI's policy provides coverage only when the nurse midwife is working in collaboration with and is performing the duties and responsibilities as assigned by the supervising physician.
- The duties and responsibilities of the nurse midwife must be within the scope and practice of the supervising physician who must be an obstetrician/gynecologist or a physician with obstetrical training and obstetrical privileges.
- I understand that as the employing physician, I certify that I will be the supervising physician of the Applicant.
- Mutually agreed upon written medical guidelines/protocol for clinical practice which confirms that ongoing communication will be in place between the supervising physician and the Certified Nurse Midwife, has been developed (must be submitted along with the application).
- Periodic and joint review and updating of the written medical guidelines/protocols by the supervising physician and certified nurse midwife will be conducted.
- Informed consent about the involvement of the supervising physician, Certified Nurse Midwife and other health care providers in the services offered is in place.
- Periodic and joint evaluation of services by supervising physician and Certified Nurse Midwife will be conducted.

Signature - Supervising Physician

Print Name - Supervising Physician

Date