Building Enduring Partnerships

LAMMICO
One Galleria Blvd.,Ste. 700 • Metairie, LA 70001 • www.lammico.com
504/831-3756 • 800/452-2120 • FAX: 504/841-5300 or 504/841-5205

Physicians and Surgeons Professional Liability Application—*Locum Tenens*

Any physician who takes over the practice of another physician on a temporary basis must complete a *locum tenens* application. Limits of the LAMMICO insured are shared with the *locum tenens* physician.
Please type or print, answer all questions completely.

Personal Information

Application # (LAMMICO use only) ☐☐☐☐☐☐☐

Name of Locum Tenens		Name of LAMMICO Insured	
Office Address (include city, state, zip)			Years at this location
Billing Address (include city, state, zip)			Other Locations (if any)
Home Address (include city, state, zip)			
Medical Group Name (if any)	Social Security No.	Date of Birth	Parish Medical Society
Office Phone	Fax Number	Home Phone	E-mail Address

Desired Coverage Period (Period you will be temporarily serving in the LAMMICO insured's place) ____________________

Underwriting and Rating Information

1.a. Do you have a current license to practice medicine in La.? ☐ Yes ☐ No La. License No.: ____________

1.b. State and Federal Narcotics License Numbers: ____________________

1.c. Do you have restrictions? (if yes, explain) ____________________ ☐ Yes ☐ No

2. List other states where licensed and license #s: ____________________

3.

Undergraduate School, Location	Degree	Year
Medical School, Location	Degree	Year
Postgraduate Training, Location	Specialty	Year(s)
Served Internship at (PG I)		Year(s)
Served Residency at (PG II - ?)		Year(s)

4. Are you certified by an approved specialty board? (if yes, which?) ____________ ☐ Yes ☐ No

5. What is your medical specialty? ____________________
NOTE: If your medical specialty is not the same as the LAMMICO insured's specialty, please describe in the remarks section the duties you will be performing while substituting for the LAMMICO insured.

6. Will you perform or assist in surgery? ☐ Yes ☐ No If yes, will this be confined to the LAMMICO insured's patients? ☐ Yes ☐ No

7. Medical or Surgical Procedures (Please indicate whether you perform any of the following):

☐ **Anesthesia** ☐ General ☐ Spinal ☐ Epidural

☐ **Assisting in major surgical procedures**

☐ **Minor Surgery & Procedures**—Includes operations and procedures not considered to be major surgery, involving primary treatment of limited abnormalities, injuries, and infections of the skin and superficial tissue, usually using local anesthesia and predominantly performed on an outpatient basis. It includes but is not limited to the following list. Check all applicable:

☐ No procedures—only consulting or diagnostic
☐ Incisions of boils and superficial abscesses
☐ Cryosurgery
☐ On benign dermatological lesions

- [ ] Suturing of skin and superficial fascia
- [ ] Acupuncture—other than acupuncture anesthesia
- [ ] Angiography
- [ ] Angioplasty
  - [ ] Coronary
  - [ ] Peripheral
- [ ] Bone fractures: closed treatment
- [ ] Cancer chemotherapy
- [ ] Catheterization
  - [ ] Cardiac
  - [ ] Transarterial
  - [ ] Occasional insertion of pulmonary wedge, recording catheters, or temporary pacemakers
  - [ ] Transvenous
  - [ ] Umbilical cord catheterization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen (other than emergency or for transport)
  - [ ] Other ______________________
- [ ] Cervical conization—specify type: ______________
- [ ] Circumcision
- [ ] Colonoscopy
- [ ] Cosmetic injections—specify type: ______________
- [ ] Cosmetic skin flaps and skin grafts: ______________
- [ ] Dermabrasion
- [ ] Diagnostic sonography
- [ ] Discograms
- [ ] Electroshock therapy (psychiatric)
- [ ] Fiberoptic bronchoscopy
- [ ] Hair transplant
- [ ] Interventional endoscopy—specify type: ______________
- [ ] Laser therapy—specify type: ______________
- [ ] Liposuction
- [ ] Myelography
- [ ] Needle biopsy
  - [ ] Lung, liver, kidney, or prostate
  - [ ] Bone marrow
  - [ ] Other
- [ ] Nerve blocks, therapeutic—specify type: ______________
- [ ] Pneumatic or mechanical esophageal dilation (not with bougie or olive)
- [ ] Radiopaque contrast material injections into blood vessels, lymphatic, sinus tracts, and fistulae
- [ ] Vasectomy
- [ ] Other ______________________

- [ ] **Major Surgery**—Includes operation procedures in or upon any body cavity including cranium, thorax, abdomen, pelvis; any other operations or procedures which, because of the condition of the patient or the length or circumstances of the operation, present a distinct hazard to life. It also includes but is not limited to the following list. Check all applicable:

- [ ] Amputations
- [ ] Bone fractures
  - [ ] Operative treatment
  - [ ] Closed manipulation-general or regional anesthesia
- [ ] Fertility or reproductive surgery
- [ ] Gynecological procedures
  - [ ] Dilation and currettements other than emergency
- [ ] Laparoscopic Cholecystectomy
- [ ] Laparoscopy
  - [ ] Diagnostic
  - [ ] Sterilization
  - [ ] Therapeutic
- [ ] Liposuction
- [ ] Minimal invasive endoscopic surgery—specify type: ______________________
- [ ] Obesity surgery—specify type: ______________________
- [ ] Obstetrical procedures
  - [ ] Abortions
    - [ ] Elective
    - [ ] Therapeutic
  - [ ] Cesarean sections
  - [ ] Forceps delivery other than outlet forceps
  - [ ] Home delivery
  - [ ] Vaginal delivery
  - [ ] Other ______________________
- [ ] Penile implants
- [ ] Percutaneous disc surgery
- [ ] Plastic surgery
  - [ ] Cosmetic—specify type: ______________
  - [ ] Breast augmentation
  - [ ] Reconstructive—specify type: ______________
  - [ ] Facial—specify type: ______________
- [ ] Radial keratotomy

- [ ] Spine surgery
  - [ ] **Primary**
    - [ ] Cervical
    - [ ] Thoracic
    - [ ] Lumbar
    - [ ] Spinal instrumentation
  - [ ] **Reoperative**
    - [ ] Cervical
    - [ ] Thoracic
    - [ ] Lumbar
    - [ ] Spinal instrumentation
- [ ] Tonsillectomies and/or adenoidectomies
- [ ] Other—specify type: ______________________________

NOTE: If you answer yes to any of the following questions, please give detailed information in the remarks section of this application. (Attach additional sheets if necessary.)

8. Has any hospital or medical staff ever restricted or revoked your privileges or invoked probation? ☐ Yes ☐ No
9. Has your license to practice medicine or narcotics license ever been revoked, voluntarily suspended, or subjected to probation or are you aware of any circumstances that might lead to such? ☐ Yes ☐ No
10. Has your membership in any medical association or society ever been refused, suspended, revoked, voluntarily surrendered or been censured? ☐ Yes ☐ No
11. Have you been treated for alcoholism, narcotic addiction or mental illness? ☐ Yes ☐ No
12. Have you now or have you ever had a chronic illness or physical defect that impairs or could tend to impair your ability to practice medicine? ☐ Yes ☐ No
13. Have you been convicted of a crime (other than a motor vehicle violation)? ☐ Yes ☐ No
14. Have fee complaints or professional relations complaints been registered against you with your medical society/association or state licensing authority within the past five years? ☐ Yes ☐ No
15. Has your professional liability insurance ever been cancelled, non-renewed, restricted or surcharged, or has your professional liability insurer ever asked you not to renew your policy? ☐ Yes ☐ No
16. Has any insurance carrier ever declined professional liability insurance to you? ☐ Yes ☐ No
17. Has any claim or suit for alleged malpractice ever been brought against you? ☐ Yes ☐ No
18. Are you aware of any circumstances that might reasonably lead to such a claim or suit? ☐ Yes ☐ No

NOTE: If you answered yes to question 18, please provide the following information to complete and expedite our underwriting review:

(1) a copy of the complete hospital chart, your office records, and a complete copy of all medical records (hospital, ambulatory care, office, etc.) pertinent to the claim;
(2) a copy of the petition filed against you, and/or any judgment or settlement if applicable; and
(3) a full typewritten narrative, in your own words, of each situation, including a statement of the facts at issue (include names, dates, places, your diagnosis, and treatment of the case).

Please be as thorough as possible in order for the Underwriting Dept. to give your application a prompt review.

19. Name of current professional liability insurance carrier including expiration date, policy number, and limits:

____

20. List names of all professional liability insurance carriers that you have been insured with for the last 10 years and dates of coverage: ______________________________

____

____

21. How many times have you changed your place of practice in the last 10 years, and what were the reasons for the changes?

____

____

Question No.	Remarks

Sign and date application in the space below.

I hereby declare that all statements and answers herein are full, complete, and true to the best of my knowledge and belief and that no material circumstance or information concerning the subject matter of the questions asked has been withheld or omitted.

I authorize any professional societies, prior or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions or persons that may have any record or knowledge concerning any of the statements and answers made herein to release such information to LAMMICO upon its request. I authorize the use of a copy of this authorization in place of the original.

Signing this application does not bind the company to renew a policy of insurance. However, it is agreed that this form shall be the basis of the policy.

____________________________ Applicant Signature

____________________________ Date