



PHYSICIANS & PROVIDER APPLICATION
Professional Liability Insurance Application
Claims Made Coverage for the Volunteer/Retired Provider Program

Please answer all questions and return this application to:
Western Washington AHEC, 2033 Sixth Ave, Suite 310, Seattle WA 98121

| | | |
|---|------|------------------------------|
| Physician or Provider Name: | | Professional Designation(s): |
| Social Security or Federal Tax I.D. Number: | | Date of Birth: |
| DEA Number: | | |
| Complete Mailing Address: | | |
| Telephone Numbers Business: | Fax: | E-Mail Address: |

- Date Volunteer service is to begin (mm/dd/yy) :** _____
- Clinic at which you will be volunteering:** _____
- Principal medical specialty or subspecialty in which you will practice:** _____
- Are you Board Certified?** Yes* No **Board Eligible?** Yes* No
 *If Yes, Name of Board: _____
- Have you participated in a risk management training program (seminar or self-study) within the past three years?**
 No
 Yes – When? _____
Please attach a copy of your certificate of completion.

6. Medical License Information:

| State | % of Practice | License Number | Expiration Date | Status |
|-------|---------------|----------------|-----------------|--------|
| | | | | |
| | | | | |

- Do you have any medical professional duties that are insured by another company or that you otherwise do not require WCC insurance coverage?**
 No
 Yes – Explain: _____
- a) Have you been involved in any claims or lawsuits in the past five years?** Yes No
 If Yes, give details:
 Date of Loss Amount Paid Claimant Name / Incident Description and Status *(Attach separate sheet if necessary)*

- b) Are there any circumstances known which may give rise to a claim or lawsuit?** Yes No
 If Yes, please explain: _____

Please note that your POLICY will not cover, nor will the COMPANY be liable for, CLAIMS based upon, arising from, or in consequence of any EVENT, if written notice of, or constructive notice of, such EVENT has previously been given to another insurer that covers CLAIMS under any coverage section of which this AGREEMENT is a replacement, or if the INSURED has constructive notice of such an EVENT and fails to disclose the EVENT to the COMPANY.



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9. Have you ever:

- a) Been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association? Yes No
- b) Been convicted of an act committed in violation of any law or ordinance other than traffic offenses?..... Yes No
- c) Been treated for alcoholism or drug addiction? Yes No
- d) Had a state professional license, state or federal license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted on a special terms or ever voluntary surrendered same? Yes No
- e) Had an insurance company cancel, decline, refuse to renew or accept on special terms malpractice insurance?..... Yes No

If you answered yes to any of the above, please explain: _____

COMMENTS:

Please use this section to fully answer any previous question or to provide further information and/or instructions.

APPLICANT REPRESENTATION, AUTHORIZATION AND RELEASE
(PLEASE READ CAREFULLY)

I hereby represent that the information contained in this application and any supplementary submission is complete and true and that no material facts which are reasonably likely to influence the judgment of the underwriter in considering this application have been omitted. **I agree that this shall be the basis of the policy of insurance requested and that I will notify Washington Casualty Company (WCC) of any changes herein.**

If you, any other person or entity insured on your policy, or any agent of yours who provides WCC with information on your behalf intentionally conceals or misrepresents any material fact or circumstances concerning this insurance, this policy will be void and WCC will rescind or cancel your policy.

I acknowledge that as a condition precedent to acceptance of this application and any future renewal thereof, an inquiry and investigation of my professional background, qualifications and competence, including such other underwriting or claim matters as are deemed relevant, may be conducted by WCC or its duly authorized representatives. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, their insurance consultants or agents, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any attending or treating physicians, any prior insurance carriers, prior employers or professional associates, and WCC or its duly authorized representatives. I hereby release and discharge the providers of information, WCC, its duly authorized representatives and the members or consultants of any established peer review committees from any and all legal liabilities which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by WCC or its duly authorized representatives. **All policies carry a restrictive endorsement that only provides coverage for noninvasive, volunteer health care, as outlined in the law (RCW 43.70.460). For medical care this includes injections, suturing of minor lacerations, and incisions of boils or superficial abscesses. Primary dental care includes diagnosis, oral hygiene, restoration and simple extractions. Obstetric care, orthodontia and invasive treatments are not covered.**

Signature _____

Date _____

I UNDERSTAND THAT SIGNATURE OF THIS APPLICATION DOES NOT BIND WCC TO COMPLETE THIS INSURANCE.
(A photocopy of this Authorization shall be considered as effective and valid as the original)

If application is complete, please return to:
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