PSIC Professional Solutions INSURANCE COMPANY

INTERSTATE HEALTHCARE

24150 Little Mack Ave,
St. Clair Shores, MI 48080
Phone: 800-419-5999

Nurse Practitioner/Physician Assistant Supplemental Questionnaire

A. APPLICANT INFORMATION

1. Name: _____ (First / Middle / Last)
2. Specialty License Number: _____
3. Name of supervising or collaborating physician: _____ (First / Middle / Last)
4. Date Employed: _____/_____/_____ (MO / DAY / YR)
5. Average number of direct patient care* hours per week: _____
6. If practicing part-time, how many years have you practiced less than 21 hours per week in direct patient care*? _____

**For the purposes of this section, direct patient care is defined as medical professional services rendered that could form the basis of a claim by a patient against the insured. This includes but is not limited to: performing medical professional services on a patient; consulting or making a diagnosis of a patient's medical condition; prescribing medicine or medical treatment; updating, dictating or reviewing a patient's medical records and supervising or consulting with healthcare staff*

B. COVERAGE INFORMATION

1. Desired effective date: _____/_____/_____ (MO / DAY / YR)
2. Desired retroactive date: _____/_____/_____ (MO / DAY / YR)
3. Select requested coverage: ☐ Shared ☐ Separate
4. In the past five years, have you been involved, directly or indirectly, in a claim* or suit arising out of the rendering or failure to render professional services? ☐ Yes ☐ No

**For the purposes of this section, the word claim is defined as any demand for damages, resolved or pending, regardless of the result, arising from your professional activity brought against you or any professional corporation or partnership.*

If you answered yes that you reported a claim, please complete the PSIC Claim Information form.

C. NURSE PRACTITIONERS (INCLUDES NP, NP-C, APN,MSN & MN)

Quality Assurance Provisions:

1. Is the collaborative or supervising agreement scheduled for periodic review and re-approval? ☐ Yes ☐ No
   If yes, please check how often is this scheduled: ☐ Semi-annually ☐ Annually
   Please provide a copy of the collaborative or supervising agreement.
2. Is there a process for chart review if the nurse practitioner's practice includes any direct patient care, education or management? ☐ Yes ☐ No
   If yes, how often are charts reviewed: _____ *If yes, how many charts are reviewed:* _____
3. Is a plan in place for resolution of disagreements regarding patient management? ☐ Yes ☐ No
4. Are practice guidelines developed by the supervising physician and approved jointly based on the scope of practice of the practitioners and within state requirements? ☐ Yes ☐ No
5. Is a copy of the agreement on file at all sites where the APN renders service? ☐ Yes ☐ No
6. Does the physician meet in person with the APN at least once a month to provide collaboration and consultation? ☐ Yes ☐ No
7. Is the physician available as needed for consultation and collaboration on medical problems, complications or emergencies, or patient referral? ☐ Yes ☐ No

C. NURSE PRACTITIONERS (INCLUDES NP, NP-C, APN,MSN & MN (CONTINUED)

8. Is another physician, with the same specialty, available for consultation in the absence of the designated collaborating physician? ☐ Yes ☐ No
   If yes, please indicate how often this occurs: ☐ Weekly ☐ Monthly ☐ Other: _____
9. Does the collaborating physician have access to all the medical records of all the patients attended to the by APN? ☐ Yes ☐ No

D. PHYSICIAN ASSISTANTS (INCLUDES PA, PA-C AND RPA)

Quality Assurance Provisions:

Please indicate if the supervising physician is continuously available for direct communication:

1. Physician is physically present where the PA is practicing ☐ Yes ☐ No
   If no, is the physician readily available through telecommunications? ☐ Yes ☐ No
   During practice hours, is the physician located less than 60 minutes away from where the PA is practicing? ☐ Yes ☐ No
2. Does the supervising physician regularly review the condition of the patients being treated by the PA? ☐ Yes ☐ No
3. Are services to be performed limited to those services under the physician's normal course of practice and expertise? ☐ Yes ☐ No

Has a quality assurance process been established that includes:

1. A routine review of selected patient record entries? ☐ Yes ☐ No
2. A routine review of selected medical orders issued by the PA? ☐ Yes ☐ No
3. A discussion of new medical developments relevant to the practice of the PA? ☐ Yes ☐ No
4. Are records of quality assurance activities maintained and available upon request? ☐ Yes ☐ No

If you answered NO to any of the above questions, please provide details here: _____

IF MORE ROOM IS NEEDED, PLEASE COPY THIS FORM OR USE A SEPARATE PIECE OF PAPER.

E. SIGNATURE REQUIRED

DO NOT CANCEL YOUR CURRENT INSURANCE POLICY UNTIL A BINDER OR POLICY HAS BEEN RECEIVED AND IS IN EFFECT FROM PROFESSIONAL SOLUTIONS.

By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate. I understand that Professional Solutions Insurance Company (PSIC) shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

I understand that the insurance for which I have applied is not in effect unless and until this application is accepted by PSIC and I am notified by the company of said acceptance.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my professional background, competence and qualifications may be conducted by PSIC.

In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to PSIC, and I expressly release and discharge the company from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by PSIC to provide the company with all information and/or documentation within their possession or under their control that pertains to my professional background, competence and qualifications, and I hereby release the providers of such information or documentation from all legal liabilities that might otherwise be incurred in connection herewith.

I agree to notify PSIC of any changes in my practice of medicine within thirty (30) days of its occurrence, including but not limited to:

- Any changes in the professional services provided by me or someone for whom I am legally responsible;

- Any changes in my profession as described in any declarations issued as a result of this application;
- Any change in the location of my practice;
- Any investigation, restriction, suspension or surrender of a state medical license, DEA license or any hospital privileges;
- Any mental or physical condition, including treatment for alcohol or substance abuse;
- Any conviction, plea or agreement related to charges of a misdemeanor or a felony (other than a minor traffic offense).

Important Reminder: The coverage for which you are applying is written on a CLAIMS MADE basis. Only claims first made against you and reported to the company during the policy period are covered, subject to policy provisions. If you have any questions, please discuss them with your agent.

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Agent Date

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