Medical Directors Professional Liability **Application**

IGP Specialty | 14241 Dallas Parkway, Suite 850 | Dallas, Texas 75254

GENERAL INFORMATION

1. Physician Applicant Name: _____
2. Address: _____
   City: _____ State: _____ County: _____ ZIP: _____
3. Phone: _____ Website URL: _____
4. Type of organization, service or facility where applicant provides services as Medical Director:

   _____
5. Name of organization: _____
6. Address: _____
   City: _____ State: _____ County: _____ ZIP: _____
7. Phone: _____ Website URL: _____
8. Extent (size) of operations of organization, service or facility, for which these units of exposure are applicable:
   Number of beds: _____ Number of outpatient visits: _____ Number of ambulances: _____
   Organization/service/facility's annual receipts (or operating budget): $ _____
9. Medical Director duties/contract: **Attach copy of contract between Medical Director and organization, including description of the duties and responsibilities of medical director, if not included in contract.**
10. Describe any circumstances wherein the applicant in his/her/their capacity as Medical Director may also be called upon to act with his/her/their capacity as a "physician" to treat, intervene in the treatment, direct the treatment, or consult in the treatment of any person (patient/client):

    _____
    How often might such circumstances occur? _____
11. Time commitment: Number of hours per month applicant will provide services as Medical Director: _____
12. Remuneration: Annual remuneration applicant will be paid for service as Medical Director: $ _____
13. **Limit of liability** requested: $ _____ per incident / $ _____ per aggregate
14. **Proposed effective date:** _____ Number of years as Medical Director: _____

APPLICANT PHYSICIAN INFORMATION

15. License number: _____ Expiration date: _____ State: _____ Years licensed: _____
    Certification: _____
16. Current practice: _____ Dates—From: _____ To: _____
    Specialty: _____ Board certified? ☐ Yes ☐ No
    Type of practice: ☐ Solo practice ☐ Partnership ☐ Group practice ☐ Other: _____
    Prior practice: _____ Dates—From: _____ To: _____
17. Medical school: _____ Date completed: _____ Degree: _____
18. Internship/residencies:
    Medical center: _____ Dates served—From: _____ To: _____
    Medical center: _____ Dates served—From: _____ To: _____
19. Hospital privileges (hospital name/address and nature of privileges):

    _____
20. Medical Malpractice insurance: **Attach certificate or other verification of current insurance.**

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21. Claims information: Has any claim or suit for alleged malpractice been brought against you in the last 5 years, or are you aware of any circumstances that might lead to such a claim/suit? ☐ Yes ☐ No
    If yes, describe event including claimant name, date of incident, suit status, amount of settlement or reserve (or attach separate sheet):

22. Sanctions: Has applicant ever had his/her/their license or certification revoked, suspended, or restricted, or been subject to any disciplinary proceeding, or been reprimanded by an administrative agency, professional association or peer committee? ☐ Yes ☐ No
    If yes, describe in detail:

STATEMENT OF NON-CONFLICT OF RELATIONSHIP

I. Applicant is NOT a principal, proprietor, superintendent, officer director, stockholder or member of the board of directors, trustees, or governors of the organization named in Item 5 of this application, nor is applicant in any other manner, except as Medical Director, affiliated or associated with said organization.

II. No patient or client of the organization named in Item 5 of this application is/will be billed or charged specifically for services afforded by the applicant whether in his/her/their capacity as Medical Director, physician or otherwise.
    Exceptions, if any, to above (absence of entry means "no exceptions"):

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

SIGNATURE PANEL

I/we hereby declare that the statements and particulars in this application are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Applicant signature _____ Date _____

Typed or printed name: _____ Title: _____

