



THE WOOD  
INSURANCE  
GROUP

## APPLICATION FOR MEDICAL PROFESSIONAL LIABILITY INSURANCE FOR A NURSE ANESTHETIST

(In CA & ME: Wood Insurance Services, In NY & VA: David A. Wood Insurance Agency)

All applicants for professional liability insurance must complete this application. This is only an application for insurance; it is not a binder, a policy or certificate of participation. Please complete the application for the risk/locations/services you are requesting coverage for under this policy. All coverage is subject to underwriting. No coverage will be considered until every question on the application has been fully answered. If you need additional space, please attach extra pages. **Please DO NOT include information (except for Section V) about services at locations that you are not requesting coverage for under the policy you are applying for with this application.**

- New
- Renewal
- Addition
- Substitute

### I. GENERAL INFORMATION

<b>1</b>	Name: _____	<input type="checkbox"/> CRNA	<input type="checkbox"/> Registered Nurse Anesthetist
<b>2</b>	Business Name: _____		
	<input type="checkbox"/> Sole Proprietorship/dba: Name	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation (Inc/LLC/PC/PA/etc)
	<b>Owner(s):</b> _____	<b>% of ownership:</b> _____	<b>% (List on separate page if necessary)</b>
<b>3</b>	Business Address: _____		
	County: _____	City: _____	State: _____ Zip: _____
<b>4</b>	Business Number: _____	Fax Number: _____	E-Mail: _____
<b>5</b>	Home Address: _____		
	County: _____	City: _____	State: _____ Zip: _____
<b>6</b>	Home Number: _____	Fax Number: _____	E-Mail: _____
<b>7</b>	Date of Birth: _____	Social Security #: _____	

### II. COVERAGE INFORMATION

<b>1</b>	<b>Desired Policy Period Effective Date:</b> _____ <i>(This date cannot be prior to the date your application is received &amp; approved.)</i>		
<b>2</b>	<b>Do you desire prior acts coverage?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<b>Desired Retroactive Date:</b> _____	
<b>A COPY OF YOUR CLAIMS-MADE POLICY SHOWING YOU AS A NAMED INSURED, THE LIMITS AND DATES OF COVERAGE AND RETROACTIVE DATE, MUST ACCOMPANY YOUR APPLICATION IF PRIOR ACTS IS DESIRED.</b>			
<b>3</b>	<i>Select Desired Limits of Liability: (Each Healthcare Incident or Event/Annual Aggregate for all Healthcare Incidents and Events)</i>		
	<input type="checkbox"/> \$1,000,000 each claim/\$3,000,000 aggregate	<input type="checkbox"/> \$250,000 each claim/\$750,000 aggregate	
	<input type="checkbox"/> \$100,000 each claim/\$300,000 aggregate	<input type="checkbox"/> \$200,000 each claim/\$600,000 aggregate	
	<input type="checkbox"/> Other: _____		

### III. PRIOR COVERAGE INFORMATION

Please provide current/expiring coverage information. <b>Please attach a copy of your current Declarations page.</b>	
<b>1</b>	Insurance Company: _____
	Policy Number: _____ Premium: _____
	Limits of Liability: _____ Policy Period: _____
	Coverage Form (Occurrence/Claims Made): _____
	Retroactive Date: _____ Deductible: _____

<b>IV. CLINICAL PRACTICE INFORMATION</b>				
1	How long have you been practicing? _____ Years	Has certification ever lapsed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2	Name of Nurse Anesthetist program from which you graduated: _____ Year Graduated: _____ Degree: _____			
3	If you have been practicing <2 years, are you supervised by an MDA/CRNA with 7+ years of experience?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
4	Are you a member of any professional association(s)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, which one(s)? _____
5	List the states and license numbers where you are currently licensed to practice: <b>Please attach a copy of your license(s).</b>			
	<b>State</b>	<b>License #</b>	<b>State</b>	<b>License #</b>
6	a. Are you self employed or an independent contractor?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	b. If no, please provide the name of your employer: _____			
7	a. Do you own (all or part) of a professional corporation, association, or partnership?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	b. If Yes, please list the names of all principles and partners: _____			
	c. What company insures these principles or partners? _____			
	d. Do you employ CRNAs or other Healthcare (HC) Professionals?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	e. Do you have independent contractors (CRNAs or other HC Professionals) working for you?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	f. Are they insured individually/separately?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
8	a. Do you supervise other Nurse Anesthetists?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	b. If Yes, are they insured individually?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
9	a. Do you own a locum tenens company?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	b. If Yes, do you have any employees or sub-contractors working for your company?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	c. If Yes, Are they insured individually/separately?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>For 7c, 7d, or 7e, as applicable please provide certificates of insurance for each.</i>				
11	Do you work with any physicians or surgeons who have no malpractice insurance?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
12	If you are an owner, operator, officer, partner, administrator or have similar capacity for any other health care or related services organization, please identify and explain: _____			
<b>Please DO NOT include information (except for Section V) about services at locations that you are not requesting coverage for under the policy you are applying for with this application.</b>				
13	I work <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time			
14	a. On average how many hours per day and days per week do you practice? Hours per day? _____ Days per week? _____			
15	What is your average weekly patient load? _____ How many require general anesthesia? _____			
16	<b>Please list ALL the facilities where you will practice using the insurance you are applying for:</b>			
	<b>Name</b>	<b>Type of Facility</b> (hospital, hospital surgery center, non-hospital surgery center, etc.)	<b>Complete Address</b>	<b>% of Time spent here</b>
			<b>Total</b>	<b>100%</b>
17	a. Are ALL the facilities you work in accredited?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

b. They are accredited by (choose all that apply):  JCAHO  AAAHC  AAAASF  Other: \_\_\_\_\_

<b>18</b>	a. Do you do locum tenens, fill-in, or vacation relief work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	b. If yes to a, please provide the # of locations you work or plan to work at _____ and the % of your services to be insured under this policy that are applicable to this type of activity _____%.	
	c. If yes to a, are your services provided on a consistent basis? <i>(Consistent basis means where you will work at least collectively 12 shifts or more at the same accredited hospital or accredited surgery center during the course of a year OR where you have an annual agreement or arrangement to provide services at the same accredited hospital or accredited surgery center. We are looking for you to have familiarity with the healthcare team and processes through working at the same accredited hospital or accredited surgery center.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	d. If yes to a, are your services provided on a short-term, inconsistent basis? <i>(Short-term, inconsistent basis means where you will not work collectively at least 12 shifts at the same accredited hospital or accredited surgery center during the course of a year or where you will not have an annual agreement or arrangement to provide services at the same accredited hospital or accredited surgery center.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. If yes to d, please describe: _____		

Give the approximate percentages of your current practice in the following areas. *(Where applicable, please indicate the split between general and local anesthesia.) Percentages indicated must total 100%.*

<b>19</b>	Bariatric Surgery _____%	Non Office Based Dental/Oral Surgery _____%	Obstetrical _____%
	Family Planning _____%	Podiatric _____%	Pediatric _____%
	Plastic/Cosmetic Surgery _____%	Non-surgical Pain Management _____%	Cardiovascular Surgery _____%
	Ophthalmological _____%	Ophthalmological including Bulbar Blocks? _____% <i>(actually doing the block)</i>	
	Research or Experimental _____%	Neurosurgery _____%	Orthopedics w/ spine _____%
	Other _____% Please describe: _____		

**Please check the description(s) below based on your practice profile. Please check ALL that apply but remember to ONLY include information about locations that you are requesting coverage for with this application.**

**I work in one or more..... *(Please check the box(es) that are applicable.)***

<b>20</b>	a. hospital(s) or hospital surgery center(s) on the hospital campus & I am MDA supervised 100% of the time. This type of setting makes up ___% of my practice. I do ___% plastics in this type of setting.	<input type="checkbox"/>
	b. hospital(s) or hospital surgery center(s) on the hospital campus & I am <b>not</b> 100% MDA supervised. This type of setting makes up ___% of my practice. I do ___% plastics in this type of setting.	<input type="checkbox"/>
	c. accredited surgery center(s) & I am MDA supervised 100% of the time. This type of setting makes up ___% of my practice. I do ___% plastics in this type of setting.	<input type="checkbox"/>
	d. accredited surgery center(s) & I am <b>not</b> MDA supervised 100% of the time. This type of setting makes up ___% of my practice. I do ___% plastics in this type of setting.	<input type="checkbox"/>
	e. <u>office based</u> settings (medical/dental office). <i>(This should NOT include free-standing, accredited surgery centers.)</i> This type of setting makes up ___% of my practice. I do ___% plastics in this type of setting.	<input type="checkbox"/>
	f. <u>non-accredited</u> surgery centers. This type of setting makes up ___% of my practice. I do ___% plastics in this type of setting.	<input type="checkbox"/>
	h. Other: _____ This type of setting makes up ___% of my practice. I do ___% plastics in this type of setting.	<input type="checkbox"/>

**21 a.** Have you provided anesthesia for any of the following in the past five years?

	Family Planning (Terminations)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Ophthalmological that includes Peri or Retro Bulbar Blocks that you performed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Procedures in an office setting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Procedures in a non-accredited surgery center?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Short-term, inconsistent locum tenens, fill-in, or vacation relief work? ( <i>Short-term, inconsistent basis means where you <b>will not</b> work collectively at least 12 shifts at the same accredited hospital or accredited surgery center during the course of a year or where you <b>will not</b> have an annual agreement or arrangement to provide services at the same accredited hospital or accredited surgery center.</i> )	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<b>b.</b> If Yes to any in <b>a.</b> , was this covered by other insurance coverage OR would coverage be needed under the policy you are applying for with this application?	<input type="checkbox"/> Covered under another policy <input type="checkbox"/> Need coverage under this policy	
<b>22</b>	Do you perform acupuncture anesthesia? If Yes, please provide details: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>23</b>	<b>a.</b> Is a portion of your practice devoted to pain management? If Yes, please list techniques used: _____ <b>b.</b> If yes, do you utilize implantation of medical devices? <b>c.</b> If Yes, please identify the types of devices, their manufacturers, and medical purpose. For each, please also indicate if they are used for benign treatment of chronic pain or for terminal patients only: _____ _____ _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>24</b>	During all anesthetics, do you use a pulse oximeter monitor? If No, please explain: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>25</b>	During all general anesthesia, do you use an end tidal CO <sub>2</sub> monitor? If No, please explain: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>26</b>	During all anesthetics is an electrocardiogram continuously displayed? If No, please explain: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>27</b>	During all anesthetics <b>how often</b> is arterial blood pressure determined and evaluated? Every _____ minutes.		
<b>28</b>	During all anesthetics <b>how often</b> is heart rate determined and evaluated?		
<b>29</b>	During all anesthetics <b>how</b> is circulatory function evaluated? _____ _____		
<b>30</b>	During all general anesthesia using an anesthesia machine, do you... <b>a.</b> use an oxygen analyzer with a low concentration limit alarm? If No, please explain: _____ <b>b.</b> test proper functioning alarm prior to each use? If No, please explain: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>31</b>	When ventilation is controlled by a mechanical ventilator, do you: <b>a.</b> use a device equipped with a full set of safety alarms? If No, please explain: _____ <b>b.</b> test proper functioning alarms prior to each use? If No, please explain: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No