Doctors & Surgeons National Risk Retention Group ("D&SN")

THE POLICY IS ISSUED BY YOUR RISK RETENTION GROUP. YOUR RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL THE INSURANCE LAWS AND REGULATIONS OF YOUR STATE. STATE INSOLVENCY FUNDS ARE NOT AVAILABLE FOR YOUR RISK RETENTION GROUP

Anesthesiology Supplement to Application for Medical Professional Liability Insurance

PRINT OR TYPE ALL INFORMATION

Although not all questions are applicable to you, please do not leave any questions unanswered. Write NONE or N/A when the question does not apply to you.

MISCELLANEOUS

1. When applicable, do you always follow the American Society of Anesthesiologists "Standards for Basic Anesthetic Monitoring", "Guidelines for Regional Anesthesia in Obstetrics" and "Guidelines for Non-Operating Room Anesthetizing Locations?" ☐ Yes ☐ No

If no, please explain: _____

2. Do you supervise any CRNAs? ☐ Yes ☐ No

If yes:

2a What is the maximum number of CRNAs that you supervise at one time? _____

2b. Do you supervise any CRNAs who provide services without you being physically present in the facility? ☐ Yes ☐ No
If yes, please explain and identify the level of supervision provided and the facility(ies):
_____

2c. Identify who employs the CRNAs: ☐ You or your group ☐ Hospital ☐ Self employed ☐ Other: _____

2d. If the CRNAs are not your or your group's employees, please:
• Provide proof of their professional liability insurance
• Provide a copy of the contract(s) or, if there is not a contract, please explain the practice arrangement :_____
2e. Please provide a copy of the protocol(s) that addresses supervision.

3. Do you cover labor and delivery? ☐ Yes ☐ No

If yes, please answer the following question.
3a. If the patient has been has been administered regional analgesia for labor, do you (or does a physician trained in anesthesia or a CRNA) remain in the hospital until the patient has delivered and the patient's condition has stabilized? ☐ Yes ☐ No

If no, please identify your (or a physician trained in anesthesia or a CRNA's) maximum response time to the hospital: _____

3b. Are VBACs performed in your hospital? ☐ Yes ☐ No

If yes, is an anesthesiologist immediately available in the hospital during active labor to provide anesthesia for an immediate Cesarean delivery? ☐ Yes ☐ No

If an anesthesiologist is not immediately available in the hospital, please explain your availability and how anesthesia coverage is provided:_____
_____

4. Do you administer anesthesia for patients who undergo spinal manipulation under anesthesia? □ Yes □ No

If yes, please identify the name(s) and designation(s) of the practitioners(s) who perform the manipulations, identify the locations where the manipulations are performed and provide proof of professional liability insurance for the practitioner(s)._____
_____
_____

5. Do you interpret electrodiagnostic studies? □ Yes □ No
If yes, please provide proof of your training.

6. Do you administer general anesthesia in any dentists' offices? □ Yes □ No

INTERVENTIONAL CHRONIC PAIN MANAGEMENT PROCEDURES

1. Please indicate with an X which of the following procedures you perform and provide the estimated number that you perform per year. _____

If you do not perform any of the procedures listed below, please check here. □

Procedure (please check)		**No. Per Year**	**Location where performed**
□ Epidural Injection □ Caudal □ Cervical □ Lumbar □ Thoracic	□ Steroid Only □ Local anesthetic with/without Steroid □ Other:_____	_____	**A**. Hospital/Hospital Surgery Center **B.** Accredited Surgery Cntr (nonhospital)* **C.** Nonaccredited Facility w/Crash Cart **D**. Other:_____
□ Facet Joint Injection □ Cervical □ Lumbar □ Thoracic		_____	Please circle: A, B, C, or D.
□ Sympathtic Nerve Injection □ Celiac Plexus □ Lumbar □ Stellate Ganglion	□Local Anesthetic_____ □ Neurolytic □ Other:		Please circle: A, B, C, or D.
□ Discography # □ Cervical □ Lumbar □ Thoracic		_____	Please circle: A, B, C, or D.
□ Epidural Lysis of Adhesions #		_____	Please circle: A, B, C, or D
□ Epidural / Spinal Endoscopy #			
□ Epidural /Spinal Catheter Placement		_____	Please circle: A, B, C, or D

□ Single-Shot Intrathecal Injection _____ Please circle: A, B, C, or D

□ Intrathecal / Epidural Infusion Pump Implant # _____ Please circle: A, B, C, or D

□ Intrathecal / epidural Infusion Pump Refilling and Reprogramming _____ Please circle: A, B, C, or D

□ Fluoroscopy _____ Please circle: A, B, C, or D

□ Lumbar Discograms _____ Please circle: A, B, C, or D

□ Neuroblative Techniques # _____ Please circle: A, B, C, or D
- □ Cryoneurolysis (a/k/a Cryoanalgesia or
- □ Cryoneuroablation
- □ Radiofrequency Nerve Ablation
- □ Other _____

□Neurostimulation Device Implants # _____ Please circle: A, B, C, or D
- □ Peripheral Nerve Stimulation
- □ Spinal cord Stimulation

□ Neurostimulation Device Reprogramming # _____ Please circle: A, B, C, or D

□ Nucleoplasty _____ Please circle: A, B, C, or D

□ Percutaneous Lumbar Discectomy # _____ Please circle: A, B, C, or D

□ Vertebroplasty / Kyphoplasty # _____ Please circle: A, B, C, or D

* Please provide proof that this location is accredited by the AAAASF, AAAHC or similar type of organization, or proof that it is certified by Medicare as an ambulatory surgery center.
# Please provide proof of your training for this procedure and the estimated number that you have performed in the Remarks section.

2. Do you perform any interventional chronic pain management procedure(s) not specified in the table above? □ Yes □ No

   If yes, please identify the procedure(s) and where you perform them: _____
   _____

3. Do any non-physician personnel perform any interventional chronic pain management procedure(s) on your behalf? □ Yes □ No

   If yes, please identify each individual, his or her designation and the procedure(s) performed by him or her: _____
   _____

4. Do you have hospital privileges for all interventional chronic pain management procedures that you perform? □ Yes □ No

   If no, please explain and identify the procedure(s) for which you do not have hospital privileges: _____
   _____

5. If you indicated that you perform any interventional pain management procedure(s) in a nonaccredited facility with a crash cart, is the crash cart equipped with at least cardiac drugs, basic airway and IV access equipment, a cardiac monitor/defibrillator *and* supplemental oxygen? ☐ Yes ☐ No

If no, please explain: _____
_____

REMARKS

Please provide any additional information to further describe your practice that has not otherwise been addressed in this questionnaire:

_____
_____
_____
_____

_____ _____
Signature of Applicant Date

_____
Print Name

Agent's Name and Address: _____
_____
_____

For questions concerning this application, please call your agent or Customer Service Representative at (706) 232-8383.