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

THIS 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

Internal Medicine 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.

Procedures

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

1A. **BIOPSIES:** If you do not perform any of the procedures below, check here: ☐

	Procedure	Number of times performed per year
	Bone Marrow	
	Breast – Needle Aspiration	
	Breast – Open	
	Endometrium	
	Intraluminal Colon	
	Kidney	
	Liver	
	Lung	
	Lymph Node – Needle Aspiration Only	
	Lymph Node – Open	
	Mouth	
	Nose	
	Scalene Node	
	Skin	
	Throat	
	Thyroid	
	Transbronchial	
	Other (specify):	

1B. **MISCELLANEOUS**

If you do not perform any of the procedures listed below, please check here: ☐

Procedure	Number of Times Performed Per Year
Arteriography	
Coronary	
Noncoronary	
Arterial Line Placement	
Bronchial Provocative Tests	
Cardioversion – Elective	
Catheterization – Right Heart	
Central Line Placement	
Endoscopy	
Anoscopy	
Bronchoscopy	
Colonoscopy – Conventional	
Colonoscopy – Virtual	
Colposcopy	
Endoscopic Retrograde Cholangiopancreatography (ERCP)	
Esophagogastroduodenoscopy	
Laryngoscopy	
Nasopharyngoscopy	
Sigmoidoscopy	
Other:	
Endoscopic Ultrasonography (EUS)	
Endoscopic Variceal Ligation (EVL)	
Endotracheal Intubation	
Esophageal Dilation	
Esophageal Sclerotherapy	
Hemorrhoid Treatment (specify):	
Lumbar Puncture/Spinal Tap	
Pacemaker Insertion	
Temporary	
Permanent	
Paracentesis	
Percutaneous Endoscopic Gastrostomy (PEG)	
Pericardiocentesis	
Pneumatic Dilation for Achalasia	
Pulmonary Function Testing & Interpretation	
Snare Polypectomy	
Stent Placement (specify):	
Thoracentesis/Pleuracentesis	
Tumor Ablation	
Venipuncture	
Ventilator Management	

2. Do you perform any procedure(s) not already specified in question 1? Yes No
If yes, please identify the procedure(s): ______________________________________
____

3. Do you have hospital privileges for all procedures specified in questions 1 and 2? Yes No
If no, please identify the procedure(s) and explain: ____________________________
____

4. Do you provide sleep medicine services? Yes No
If yes, please describe, including the type(s) of services and the location(s) where the services are provided?____
____

5. Do you provide critical care services, other than those that might be required in emergent situations? Yes No

If yes, and you have not completed an ACGME or AOA-approved fellowship in critical care medicine, please do the following:
Provide proof of your training and hospital privileges for critical care
Identify the type(s) of critical care services that you provide, the location(s) where you provide the services and the percentage of your practice devoted to critical care medicine.
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____
____

6. Do you administer chemotherapy medication? Yes No

If yes, and you have not completed an ACGME or AOA-approved fellowship in oncology, please explain and provide proof of your training, your informed consent form, and your written protocol.
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____
____

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.