

U.S. Risk, LLC | 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.**

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: _____