



ACE USA

INDIVIDUAL PODIATRISTS APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

The following are representation of facts known by you to be true. You agree that any coverage issued will be contingent upon the truth thereof and upon final approval by the insurance company. *If a policy is issued, this application will become a part of the policy. Please fully complete this application, as an incomplete application cannot be evaluated.*

I. ABOUT YOU

1. Name	2. Date of Birth	3. Social Security No.	4. Professional Degree: DPM MD Other _____
5. Name of Your Practice			
6. Primary Practice Location — Street			
7. City	8. County	9. State	10. Zip

IF YOU OWN MORE THAN ONE LOCATION, COMPLETE THE MULTI-PODIATRIST SUPPLEMENT.

11. Mailing Address if Different from Above			
12. Phone	13. Fax	14. Alternate Phone No.	15. E-mail address
16. Podiatric/Medical School		17. Year Graduated	18. Date you began practice
19. I completed an Internship Residency Preceptorship	or # of Years	Year Completed	Name of Hospital/Podiatrist where completed:
20. Narcotic/Drug License Numbers	State(s)	Expiration Date(s)	Please supply copy of license(s).
21. Podiatric/Medical License Number(s)	State(s)	Expiration Date(s)	Please supply copy of license(s).

22. Please provide the name(s) of your professional liability carrier(s) for the last three years, policy number, limits and coverage date. Check if claims-made or occurrence.

Insurance Company	Premium	Policy No.	Policy Limits	Coverage Dates	Type
					Claims-Made Occurrence
					Claims-Made Occurrence
					Claims-Made Occurrence

23. Requested policy effective date	24. Retroactive Date
25. LIMITS OF LIABILITY DESIRED (PER CLAIMS/AGGREGATE) Some limits are not available in certain states. \$1,000,000/\$3,000,000 Other: \$ _____	
26. Deductible amount desired (per claim/aggregate) — NOTE: The deductible does not apply to expense. No Deductible \$5,000 \$10,000 \$ _____	

PLEASE EXPLAIN ALL YES ANSWERS (BELOW) IN THE REMARKS SECTION.

27. Have you practiced without professional liability insurance in the last 5 years?	Yes	No
28. Has there been a General Liability or Professional Liability claim or suit (settled or pending) made against you?	Yes	No

52. Number of Podiatric office personnel:

Employed Podiatrists	Employed Nurses	Employed Nurse Anesthetists	Employed Medical Assistants	Employed Licensed Podiatric Assistants	Employed Physio-Therapists
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53. Number of Independent Contractors (I.C.) Podiatric office personnel:

I.C. Podiatrists	I.C. Nurses	I.C. Nurse Anesthetists	I.C. Medical Assistants	I.C. Licensed Podiatric Assistants	I.C. Physio-therapists
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NOTE: Podiatric professional liability coverage extends to any EMPLOYEE (other than a podiatrist, physician, surgeon, other medical doctor or nurse anesthetist) while acting within the scope of his or her duties.

III. OFFICE PROCEDURES

54. What type of informed consent do you use? Oral Written None
If oral: is chart noted, dated, and initialed by patient? Yes No
55. Do you obtain a complete patient medical history?
 Please attach a copy of your medical history form. Yes No
56. How often do you or your staff update patient medical histories? Each visit Occasionally No policy
 If occasionally, what is your procedure?
57. Do you have written procedures for you and your staff to handle health related emergencies? Yes No
58. Are you and/or your staff certified in Basic Life Support (CPR)? Yes No Certified in ACLS? Yes No
59. Do you follow OSHA and CDC guidelines for infection control? Yes No
60. Do you have a 24-hour emergency phone number for patients to reach you after hours? Yes No
61. Is on-the-spot surgery ever performed on the first visit with a patient (except for nail-related procedures)? Yes No
62. Do you consult with the patient's primary care physician on underlying health conditions, i.e., diabetes, heart, existing infections, etc.? Yes No
63. Do **you** administer General Anesthesia, I.V. or Conscious Sedation?
If YES, fill out the anesthesia supplement. Yes No
64. Do you require certificates of insurance from persons administering anesthesia? Yes No

65. List all locations where you have practiced in the last ten years:

Street	City	State	County	During years

66. List all hospitals and surgery centers at which you currently have privileges and show percentages of work at each location:

If you need a certificate of insurance, mark the box to the left of the hospital or surgi-center.

Certificate Needed	Location

67. Please check the professional organizations to which you belong:

- | | |
|---|---|
| Am. College of Foot & Ankle Orthopedics & Medicine (ACFAOM) | Am. Board of Podiatric Surgery (ABPS) |
| Am. Podiatric Medical Association (APMS) | Academy of Ambulatory Foot Surgery (AAFS) |
| Am. College of Foot Surgeons (ACFS) | Other _____ |

68. No. of patients YOU treat per week:	69. Number of referrals from other Podiatrists each month:
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70. Please list the annual percentage of procedures you perform. **(Should total 100%)**
 Non Surgical: _____% Soft Tissue Surgery: _____% Osseous Surgery: _____%

