Galen Insurance Company
231 South Bemiston, Suite 1000
St. Louis, MO 63105
Telephone: (314) 721-2366
Facsimile: (314) 721-2377

ALLIED PROFESSIONAL SUPPLEMENTAL APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE

THIS DOCUMENT IS NOT A BINDER OR ACCEPTANCE OF INSURANCE. Completion of this form, with or without payment of premium, does not bind the Galen Insurance Company ("Company") to issue insurance.

Please answer all questions fully and completely. If the applicant does not have enough space to provide a complete answer, please use Part VII, the Comments Section, of this supplemental application, or attach separate page(s), to identify the question and provide the additional information necessary for a complete answer. PLEASE TYPE OR PRINT LEGIBLY

The applicant allied professional must personally complete this supplemental application. All questions must be answered. For questions that do not apply to the applicant's practice situation, please write "N/A" in the answer space provided. If the professional does not know the answer to a particular question, please note that in Part VII, the Comments Section, of this supplemental application. All questions should be answered based on the knowledge of, and information known to, the professional applicant. If additional forms are required or if a question arises about the application process, please call the Company at: 314-721-2366.

PART I - GENERAL INFORMATION

1. Full Legal Name:_____
   Include all names by which you have been known, and dates during which the name was used.

2. Date of Birth:_____ 3. ☐ Male ☐ Female

4. License/Certificate:_____ 5. SS#:_____

6. Are you a U.S. Citizen? ☐ Yes ☐ No; If no, please describe your current status, including your intentions regarding future citizenship:_____

PART II - EDUCATIONAL HISTORY AND BOARD CERTIFICATION

1. School: _____ Dates: From _____ To _____
   City:_____ State:_____ Country:_____ Degree:_____

2. School: _____ Dates: From _____ To _____
   City:_____ State:_____ Country:_____ Degree:_____

3. School: _____ Dates: From _____ To _____
   City:_____ State:_____ Country:_____ Degree:_____

4. Other Training:
   Name , location, and type: _____ Dates: From _____ To _____
   Name, location, and type: _____ Dates: From _____ To _____

5. List the states in which you are currently licensed:
   State:_____ License Type/No.:_____ Active? ☐ Yes ☐ No
   State:_____ License Type/No.:_____ Active? ☐ Yes ☐ No

6. Identify all medical and professional societies to which you belong:_____
   _____

PART III - PRACTICE HISTORY

1. Are you entering private practice for the first time? ☐ Yes ☐ No

2. If you are in training, in your first two years of practice, or began practice in Missouri within the past two years, please attach three letters of recommendation.

3. List all locations (names and addresses) where you have, are or will be practicing:
   Present location:_____ Dates: From _____ To _____
   Present location:_____ Dates: From _____ To _____
   Prior location:_____ Dates: From _____ To _____
   Prior location:_____ Dates: From _____ To _____

4. Please explain any gaps in your training or practice:_____
   _____

5. How many category 1 credit hours of continuing medical education do you attend annually? _____

6. Do you hold any positions as director or trustee of any licensed hospital or medical institution? ☐ Yes ☐ No
   If yes, please provide complete details in Part VII of this supplemental application.

7. Do you work in an "urgent care" or similar setting? ☐ Yes ☐ No
   If yes, please provide complete details in Part VII of this supplemental application.

8. Do you perform any medical legal evaluations? ☐ Yes ☐ No
   If yes, for whom?_____
   What percentage of your practice does this entail? _____%

9. Do you have any teaching responsibilities? ☐ Yes ☐ No
   If yes, identity name and location of institution:_____
   Does this institution provide you with coverage for your supervision? ☐ Yes ☐ No
   What percentage of your weekly time is spent supervising? _____%
   If coverage is not fully provided by the entity, please attach a copy of your contract or letter of agreement.

10. Do you employ or supervise any allied professionals? ☐ Yes ☐ No
    If yes, specify the number, role and type of allied professional.

Number:	Employ or Supervise:	Type:

11. Will you be performing activities that will be covered by another professional liability policy? ☐ Yes ☐ No
    If yes, please provide details, proof of coverage, include name and address of entity in Part VII of this supplemental application.

12. Do you treat prison or jail inmates? ☐ Yes ☐ No
    If yes, please provide complete details in Part VII of this supplemental application.

13. Are you employed by the United States Military Service? ☐ Yes ☐ No

14. Are you employed by the State of Missouri? ☐ Yes ☐ No
    If yes, indicate percent of time involved in private practice _____%

15. Do you provide medical information or advice, interpret films, prescribe medications, or sell any products or services via telecommunication, video, or information systems? ☐ Yes ☐ No

16. Do you perform consultation, read X-Rays, or interpret test results for physicians or organizations who render professional services in any manner including telemedicine in another state? ☐ Yes ☐ No
If yes, please provide complete details in Part VII of this supplemental application, including number of hours per week practicing out-of-state, the number of patients seen, the number of diagnostic tests read and interpreted, and the percentage of total practice that is out-of-state.

17. Do you participate in quality assurance, peer, or utilization review activities for others? ☐ Yes ☐ No

18. Do you have management responsibilities at a facility or organization not owned by you? ☐ Yes ☐ No

19. If yes to Questions 17 or 18, is your malpractice insurance coverage provided by the entity? ☐ Yes ☐ No
If yes, please provide complete details in Part VII of this supplemental application, including the name and location of entity, your title and responsibilities and duties.
If coverage is not fully provided by the entity, please attach a copy of your contract or letter of agreement.

20. Have your practice specialties or procedures changed in the past five (5) years? ☐ Yes ☐ No
If yes, please provide complete details in Part VII of this supplemental application of how the specialties or procedures have changed and give the dates of changes.

21. Do you serve on a trauma team? ☐ Yes ☐ No
If yes, please provide complete details in Part VII of this supplemental application.

22. Please complete the following information regarding the patient volume of your practice (weekly average):
Number of patients seen by you in the office: _____ per week
Number of patients seen by you in the hospital: _____ per week
Walk-in patients _____ per week
Total _____ per week

23. Please indicate average number of hours per week that you spend in the following:
Office practice:_____ hours Emergency room:_____ hours
Hospital practice:_____ hours On-call: _____hours

24. Do you practice any form of complementary and alternative medicine? ☐ Yes ☐ No
If yes, please provide complete details in Part VII of this supplemental application.

25. Do you practice (or are you employed) in any other capacity not already identified thus far in this supplemental application? ☐ Yes ☐ No
If yes, please provide complete details in Part VII of this supplemental application.

26. PLEASE REVIEW CAREFULLY AND CHECK AND COMPLETE ALL THAT APPLY TO YOUR PRACTICE, EVEN IF THE PROCEDURES ARE OUTSIDE YOUR SPECIALTY OR DUPLICATIVE. For any item marked with an asterisk, please provide training and certificates of completion.

- ☐ Abdominoplasty
- ☐ Abortions – First Trimester; # Per Year:_____
- ☐ Abortions – Therapeutic
- ☐ Acupuncture, anesthesia
- ☐ Acupuncture, therapy
- ☐ Acupuncture, other
- ☐ Amniocentesis
- ☐ Anesthesia – surgical
- ☐ Anesthesia – caudal
- ☐ Anesthesia – epidural
- ☐ Anesthesia - general
- ☐ Anesthesia – Local
- ☐ Angiography – lymph
- ☐ Angiography, other _____
- ☐ Angioplasty
- ☐ Appendectomy: # Per Year:_____
- ☐ Arteriography
- ☐ Assisting in Surgery – own patients
- ☐ Assisting in Surgery – Patients of Others
- ☐ Autologous Fat Injection – Breast
- ☐ Autologous Fat Injection – Penis
- ☐ Bartholin cyst or abscess, I&D
- ☐ Biopsy, Breast, cyst aspiration
- ☐ Biopsy, Breast, excisional
- ☐ Biopsy, Breast, incisional
- ☐ Biopsy, Breast needle
- ☐ Biopsy , Cervical
- ☐ Biopsy, Heart
- ☐ Biopsy, Liver
- ☐ Biopsy, Skin
- ☐ Biopsy, Other _____
- ☐ Blepharoplasty – Cosmetic
- ☐ Blepharoplasty - Functional
- ☐ Blocks - Caudal Epidural
- ☐ Blocks - Celiac Plexus
- ☐ Blocks - Cervical

- ☐ Blocks - Cervical Epidural
- ☐ Blocks - Differential Spinal
- ☐ Blocks - Facet Injection, Lumbar only, under Fluoroscopy
- ☐ Blocks - Facet Injection, other than Lumbar, under Fluoroscopy
- ☐ Blocks - Facet Joint Block
- ☐ Blocks - Lumbar
- ☐ Blocks - Lumbar Epidural
- ☐ Blocks - Lumbar Sympathetic
- ☐ Blocks - Motor Point and Peripheral Nerve
- ☐ Blocks - Peripheral Nerve
- ☐ Blocks - Retrobulbar
- ☐ Blocks – Spine*
- ☐ Blocks - Spinal Nerve
- ☐ Blocks – Non-spine*
- ☐ Blocks - Stellate Ganglion
- ☐ Blocks - Subarachnoid Block
- ☐ Blocks - Supraclavicular
- ☐ Blocks - Suprascapular Nerve
- ☐ Blocks - Sympathetic Nerve
- ☐ Blocks - Thoracic
- ☐ Blocks - Trigger Point Pain Injection
- ☐ Bone Marrow Aspiration
- ☐ Bone marrow biopsy
- ☐ Botox Injections - Cosmetic*
- ☐ Botox Injections – Pain Management*
- ☐ Botox Injections – Other*
- ☐ Breast Augmentation or Reduction
- ☐ Browplasty/Brow Lift
- ☐ Buccal Fat Extraction
- ☐ Cardiac Bypass Pump
- ☐ Cardiac Catheterization, Left Heart
- ☐ Cardiac Catheterization – Right Hearth (Swan Ganz)
- ☐ Cardiac Catheterization – Right Heart (Swan Ganz)
- ☐ Cataract Surgery, lens implant
- ☐ Cataract Surgery, no lens implant
- ☐ Cesearean section
- ☐ Cervical Discograms
- ☐ Cervical Disc Nucleoplasty
- ☐ Chalazion Excision from Eyelids
- ☐ Chelation Therapy
- ☐ Chemical Peel
- ☐ Chemical face peel with phenol*
- ☐ Chemotherapy
- ☐ Circumcisions – Adult
- ☐ Circumcisions – Pediatric
- ☐ Closed reductions of simple fractures; # Per Year:_____
- ☐ Closed reductions - other; # Per Year:_____
- ☐ Collagen Injection
- ☐ Colposcopy
- ☐ Cone biopsy
- ☐ Cordotomies
- ☐ Corneal Transplant
- ☐ Cosmetic, Other - Identify all procedures not listed on separate sheet
- ☐ Cosmetic, Ear Surgery
- ☐ Cosmetic, Major Surgery
- ☐ Cryanalgesia
- ☐ Cryosurgery, benign or pre-malignant dermatological lesions
- ☐ Cryotherapy
- ☐ Cystoscopy
- ☐ D&C; # Per Year:_____
- ☐ Dermabrasion/ Chemabrasion
- ☐ Dermatology
- ☐ Dermatology: Acne surgery
- ☐ Dermatology: Collagen injection
- ☐ Dermatology: Liposuction
- ☐ Dermatology: MOHS surgery
- ☐ Dilation and Curettage
- ☐ Digital Subtraction Angiography
- ☐ Dilation and Currettage
- ☐ Discograms
- ☐ Dorsal Column Stimulator Implant or Reprogram
- ☐ Electric Shock Therapy
- ☐ Electrosurgical Procedures
- ☐ Endometrial Aspiration
- ☐ Endometrial Biopsy
- ☐ Endoscopy – Bronchoscopy
- ☐ Endoscopy, Colonoscopy
- ☐ Endoscopy, Esphagoscopy
- ☐ Endoscopy, Gastroscopy
- ☐ Endoscopy, Pelvioscopy
- ☐ Endoscopy, Protoscopy
- ☐ Endoscopy, Sigmoidoscopy, flexible to 65cm
- ☐ Endoscopy, Signoidoscopy, flexible to above 65cm
- ☐ Ensocsopy, Sigmoidoscopy, rigid
- ☐ Endoscopy, ERCP
- ☐ Endoscopy, Other: _____
- ☐ Enucleation
- ☐ Epidural or Spinal Catheters
- ☐ Epikeratophakia (KME)
- ☐ EPS (provocable electrophysiologic tests)
- ☐ Excisions, Simple
- ☐ Excisions of skin lesion(s) with graft or flap repair
- ☐ Fertility Counseling / Artificial Insemination
- ☐ Fibrel Injection
- ☐ Face Lifts
- ☐ Fat Transplantation
- ☐ FDA Approved Experiments
- ☐ Fracture Reduction – Closed – Simple
- ☐ Fracture Reduction – Closed – Other than Simple
- ☐ Fracture Reduction – Open
- ☐ Fluroscopy
- ☐ Gastic Balloon
- ☐ Hair Transplant - Human Hair
- ☐ Hair Transplant - Synthetic Hair Fibers
- ☐ Hand Surgery
- ☐ Hemorrhoidectomies; # Per Year:_____
- ☐ Hemorrhoidectomy – Ligation Only
- ☐ Hemorrhoidectomy – Other than Ligation
- ☐ Histories and Physicals
- ☐ Home Services
- ☐ Human Growth Hormone
- ☐ Hypnosis
- ☐ Hysterectomy – Abdominal
- ☐ Hysterectomy - Other
- ☐ In Vitro Fertilization (IVF)
- ☐ Independent Medical Evaluations
- ☐ Injections for chymopapain or those containing sclerosing agents
- ☐ Intraop EEG/EP Monitor
- ☐ Intravascular absolute alcohol embolization
- ☐ Intra-Articular Block (Joint Injections)
- ☐ Intradiscal Electrothermal Therapy
- ☐ Intravenous Regional Anesthesia
- ☐ IUD Insertion or Diaphragm Fitting
- ☐ Jejuno-ileal bypass or gastric bubble procedures for treatment of morbid obesity
- ☐ Joint Injection (Intra-articular Block)
- ☐ Keratotomy
- ☐ Laceration Repairs
- ☐ Laparoscopy
- ☐ Laser Hair Removal
- ☐ Laser Skin Resurfacing – Face Only
- ☐ Laser Skin Resurfacing – Other
- ☐ Laser Surgery
- ☐ LASIK*
- ☐ Leeps/Leetz Procedure
- ☐ Lens implant, no cataract surgery
- ☐ Lid Repair
- ☐ Lumbar Discograms
- ☐ Lumbar Disc Nucleoplasty
- ☐ Lumpectomy-Superficial Skin Lesion
- ☐ Lumpectomy – Other
- ☐ Mammoplasty
- ☐ Management of Ectopic Pregnancy
- ☐ Manipulation or Massage
- ☐ Manipulation Under Anesthesia
- ☐ Mastectomy
- ☐ Mesotherapy
- ☐ Myelography
- ☐ Myofascial Trigger Point Injections
- ☐ Myringotomy
- ☐ Needle Biopsy – including lung and prostrate
- ☐ Needle Biopsy – including liver, kidney, or bone marrow biopsy
- ☐ Nerve Root Injections
- ☐ Non-FDA Approved Experiments or Studies
- ☐ Nuclear Medicine
- ☐ Obstetrical Deliveries – Birthing Center; # per YR:_____
- ☐ Obstetrical Deliveries – Birthing Center; # per YR:_____
- ☐ Obstetrical Deliveries – Home or Other; # per YR:_____
- ☐ Office Gynecology
- ☐ Ophthalmic plastic surgery, cosmetic
- ☐ Orthopedic: Non-surgical care ONLY
- ☐ Otoplasty
- ☐ Pacemaker implant-temporary
- ☐ Pacemaker implant, permanent
- ☐ Pain Control or Management – Medication Only
- ☐ Pap Smears
- ☐ Paraentisis
- ☐ Pars plana vitrectomy
- ☐ Pelvic Examination
- ☐ Percutaneous Discectomy
- ☐ Percutaneous Transluminal Coronary Angioplasty
- ☐ Percutaneous Valvuloplasty
- ☐ Peripheral Nerve Stimulation
- ☐ Photorefractive Keratotomy (PRK)
- ☐ Phototherapeutic Keratotomy (PTK)
- ☐ Physical Therapy

- ☐ Prenatal Exam – Diagnose Only (refer to others)
- ☐ Prenatal Exam – 1st Trimester
- ☐ Prenatal Exam – 2nd Trimester
- ☐ Prenatal Exam – 3rd Trimester
- ☐ Pneumoencephalography
- ☐ Prolotherapy
- ☐ Prolotherapy with Phenol
- ☐ Prolothearpy without Phenol
- ☐ Radio Frequency Nerve Ablation
- ☐ Radial Keratotomy
- ☐ Radiation Therapy
- ☐ Radioplaque dye injections into blood vessels, lymphatic, sinus tracts and fistulae
- ☐ Rapid Detoxification
- ☐ Refractive keratoplasty, other
- ☐ Removal of moles and warts
- ☐ Renal Dialysis
- ☐ Retinal detachment surgery
- ☐ Retrobulbar mass
- ☐ Rhinoplasty - Cosmetic
- ☐ Rhinoplasty – Functional Only
- ☐ Scar Revisions or Repair
- ☐ Scalp Reductions
- ☐ Sclerotherapy (the injection of sclerosing agents) into the vertebral column
- ☐ Sex Change Surgery
- ☐ Silicone Injection
- ☐ Silicone Implant
- ☐ Sperm Banks for other than storage for insemination of your own patients
- ☐ Sphenopalatine Lesioning
- ☐ Spinal Infusion Pump – Implants
- ☐ Spinal Infusion Implants or Removal
- ☐ Spinal Infusion Pumps Refilling or Reprogramming
- ☐ Spinal Stimulation Implants
- ☐ Spinal Stimulation Programming
- ☐ Spinal Surgery
- ☐ Steroid injections for bursitis
- ☐ Suction Assisted Lipectomy (SAL) – Hips/Buttocks/Abdomens/Thighs*
- ☐ Suction Assisted Lipectomy (SAL) – Full Body*
- ☐ Suction Assisted Lipectomy (SAL) – limited to Head/Neck*
- ☐ Suction Assisted Lipectomy (SAL) – Eye Area*
- ☐ Suction Assisted Lipectomy (SAL) – Arms
- ☐ Surgery
- ☐ Surgery: Amputation (major)
- ☐ Surgery: Appendectomy
- ☐ Surgery: Bariatric
- ☐ Surgery: Biliary
- ☐ Surgery: Bunionectomy
- ☐ Surgery: Cardiac
- ☐ Surgery: Carpal tunnel release; # Per Year:_____
- ☐ Surgery: Closed Reduction; # Per Year:_____
- ☐ Surgery: Colon
- ☐ Surgery: Excisions of superficial lesions; # Per Year:_____
- ☐ Surgery: Ganglionectomy; # Per Year:_____
- ☐ Surgery: Hand ONLY
- ☐ Surgery: Hand - Arthrocentesis
- ☐ Surgery: Hand - Aspiration or Injection of Fingers, Wrist or Shoulder
- ☐ Surgery: Hand - Bone, tendon, nerve graft
- ☐ Surgery: Hand - Capsulectomy for joint stabilization
- ☐ Surgery: Hand - Capsulectomy or capsuloplasty for contracture
- ☐ Surgery: Hand - Complex Soft Tissue Repair; # Per Year:_____
- ☐ Surgery: Hand - Debridement/excision of nails not including the nail matrix or complicated nail bed reconstruction
- ☐ Surgery: Hand - Foreign body removal to include wire pin, screw, plate
- ☐ Surgery: Hand - Injection of tendon sheath, ligament or trigger point
- ☐ Surgery: Hand - Joint Replacement
- ☐ Surgery: Hand - Local flaps not including distant
- ☐ Surgery: Hand - Pedicle, free, etc.
- ☐ Surgery: Hand - Percutaneous or Internal Fixation
- ☐ Surgery: Hand - Scar revision
- ☐ Surgery: Hand - Skin graft
- ☐ Surgery: Hand - Synovectomy, tenosynovectomy
- ☐ Surgery: Hand - Tenovaginotomy for "Trigger" Finger; # Per Year:_____
- ☐ Surgery: Hand - Thenar Muscle Release for Contracture
- ☐ Surgery: Hand and Others
- ☐ Surgery: Herniorrhaphy
- ☐ Surgery: Herniorrhaphy (only inguinal, femoral epigastric or umbilical)
- ☐ Surgery: Implants - Type:_____
- ☐ Surgery: Incision of boil or superficial abscess
- ☐ Surgery: Injection treatment of varicose veins
- ☐ Surgery: Intestinal resection
- ☐ Surgery: Joint Replacement
- ☐ Surgery: Laminectomy
- ☐ Surgery: Laparoscopic Cholecystectomy
- ☐ Surgery: Lipectomy
- ☐ Surgery: Major Assist Only
- ☐ Surgery: Major
- ☐ Surgery: Mastectomy
- ☐ Surgery: Morton's neuroma; # Per Year:_____
- ☐ Surgery: Neurological – Other Major Procedures
- ☐ Surgery: Open Reduction
- ☐ Surgery: Organ transplant
- ☐ Surgery: Other Major Procedures
- ☐ Surgery: Percutaneious or Internal Fixation
- ☐ Surgery: Plastic, Cosmetic
- ☐ Surgery: Plastic, Reconstructive
- ☐ Surgery: Primary Extensor Tendon Repair (foot or hand); # Per Year:_____
- ☐ Surgery: Prostatectomy
- ☐ Surgery: Spinal Column
- ☐ Surgery: Submucous Nasal Resection
- ☐ Surgery: Thoracic
- ☐ Surgery: Total Joint Replacement
- ☐ Surgery: Thyroidectomy
- ☐ Surgery: Urological
- ☐ Surgery: Vascular
- ☐ Surgery: Weight Control
- ☐ Surgery: Weight Control, Intestinal Bypass
- ☐ Surgery: Weight Control, Other Abdominal Surgery
- ☐ Surgery: Suture Skin and Superficial Facia
- ☐ Surgery: Tenotomoy of Toes; # Per Year:_____
- ☐ Surgery: Tonsillectomy or Adenoidectomy
- ☐ Surgery: Transplants - Type:_____
- ☐ Surgery: Other:_____
- ☐ TAH/BSO
- ☐ Tattoo, tattoo removal or repair, cosmetic tattooing
- ☐ T & A's; # Per Year:_____
- ☐ Tendon Repair
- ☐ Therapeutic Radiology
- ☐ Thoracic Sympathectomies
- ☐ Trigeminal Lesioning
- ☐ Tubal ligation, post partum
- ☐ Tubal ligation, other
- ☐ Ultrasound – For Obstetrics
- ☐ Ultrasound - Other
- ☐ Use of chorionic gonadotropin in treatment of obesity
- ☐ Use of Laetrile (Amygdalin or Vitamin B-17)
- ☐ Vaginal delivery
- ☐ Vasectomy
- ☐ Vein Stripping*
- ☐ Vertebroplasty
- ☐ Weight control treatment - diet only
- ☐ Weight control treatment, non surgical
- ☐ Weight control drugs dispensing, (as opposed to prescribe)
- ☐ X-ray interpretation of chest, extremity, rib and clavicle films
- ☐ Other non-surgical: _____
- ☐ Wound Débridement

27. Do you provide services in connection with any surgery in your office? ..... ☐ Yes ☐ No
If yes, describe and include type of anesthesia (local, sedation, general):_____

28. Do you provide services in connection with any surgery in other non-hospital facilities? ..... ☐ Yes ☐ No
If yes, name the facilities and type of surgical procedures performed._____
_____

29. In the course of surgery described above, is general anesthesia administered?
by you? ..... ☐ Yes ☐ No
by others? ..... ☐ Yes ☐ No

30. Do you personally provide pre-operative exams and post-operative care for all surgical patients? ..... ☐ Yes ☐ No
If no, please explain: _____

31. The following specialties must request and complete the supplemental application for their specialty.

[TO BE DETERMINED]

PART IV - HOSPITAL AND OTHER AFFILIATIONS

1. Please list below all hospitals where you hold or are applying for privileges and the percentage of hospital time worked at each. Percentages should add up to 100%.

Hospital:_____	Privileges Type:_____	Time:_____%
Hospital:_____	Privileges Type:_____	Time:_____%
Hospital:_____	Privileges Type:_____	Time:_____%

2. Do you provide, or are you subject to providing, emergency care in a facility? ..... ☐ Yes ☐ No
If yes, is your work for your own patients only? ..... ☐ Yes ☐ No
Is your work required for staff privileges? ..... ☐ Yes ☐ No
Is there a written contract of agreement concerning your emergency care responsibilities? ..... ☐ Yes ☐ No
If provided at a facility (e.g., hospital, urgent care), is insurance coverage provided by the facility? ..... ☐ Yes ☐ No
Do you desire coverage for your emergency care services? ..... ☐ Yes ☐ No
If yes, please provide complete details of the emergency care services you provided in Part VII of this supplemental application.

3. Please provide the following information below or in Part VII of this supplemental application:
   (a) name of all medical service entities (including partnerships) and other health care related service organizations in which you have an interest (e.g., ownership, employment, service contractor, etc);
   (b) identify your interest or relationship (e.g., sole or partial owner, administrator, officer, teaching responsibilities, department director, etc.);
   (c) the basis for your relationship (e.g., oral contract or written contract, if written contract, submit a copy);
   (d) the number of hours per week you work in the above capacity(ies) for organization;
   (e) whether malpractice insurance coverage is provided by the organization; and
   (f) if malpractice coverage is not provided, whether coverage is sought. If coverage is being sought under this supplemental application, please provide full details of practice and professional services provided.

PART V - PERSONAL AND INSURANCE HISTORY

If you answer yes to the any of the following questions, please provide complete details in Part VII of this supplemental application.

1. Have you ever had your membership in any professional society or association refused, suspended, revoked or ever received any criticism or reprimand from any professional society? ..... ☐ Yes ☐ No

2. Have you ever been investigated, disciplined, censured, or reprimanded by a professional society or board or a licensing board? ..... ☐ Yes ☐ No

3. Are there any restrictions on your current hospital privileges? ☐ Yes ☐ No

4. Has any hospital or other institution ever restricted, reduced, refused or suspended your privileges or invoked probation? ☐ Yes ☐ No

5. Have you ever been under any hospital disciplinary observation, preceptorship or sponsorship? ☐ Yes ☐ No

6. Have you ever voluntarily surrendered or had your license to prescribe or dispense narcotics refused, suspended, limited in any way or revoked? ☐ Yes ☐ No

7. Are you now on probationary status? ☐ Yes ☐ No

8. Have you ever been investigated, charged with or convicted of a violation of a federal, state or local law other than routine traffic offenses? ☐ Yes ☐ No

9. Have you ever voluntarily surrendered or had any state license to practice medicine refused, restricted, suspended or revoked? ☐ Yes ☐ No

10. Have you ever been treated for alcoholism, mental illness or narcotics addiction? ☐ Yes ☐ No

11. Have you ever used any intoxicant, narcotic or other psycho-active drug to the extent that it either has interfered with your ability to perform professional services or caused you to seek medical advice or treatment? ☐ Yes ☐ No

12. Do you currently have any health problem, illness or physical condition that impairs or could impair your ability to practice medicine? ☐ Yes ☐ No
If yes, please submit a letter from your treating physician addressing your state of health and whether any conditions exist that could adversely affect the practice of medicine by you.

13. Has any physician, professional or patient ever filed a complaint against you with any professional society, licensing board, board of examiners, or similar organization? ☐ Yes ☐ No
If yes, please provide copies of complaint and disposition documents.

14. In the last 10 years, have you had or are you aware of a claim, suit or incident likely to become a medical malpractice claim? ☐ Yes ☐ No
If yes, please complete Form A attached for each claim, suit or incident and submit the completed Form A with this supplemental application.

15. Were each of those claims, suits or incidents reported to your malpractice insurer(s)? ☐ Yes ☐ No
If the incident was not reported to your malpractice insurer, please provide an explanation.

PART VI – INFORMATION REQUIRED - CHECKLIST

Please submit the following, along with this supplemental application and the other information requested in this supplemental application:

- ☐ Licenses and cerficiations.
- ☐ Curriculum vitae.
- ☐ Most recent certificates for completion (attendance) for continuing medical education programs.
- ☐ All written contracts concerning emergency care responsibilities.
- ☐ Authorization for release of information (see form attached) signed by you.
- ☐ Completed Form A for all claims, suits and incidents in the past 10 years.
- ☐ Completed supplemental applications for all required specialties and procedures.

PART VII – COMMENTS SECTION **(use additional sheets as necessary)**

Page Number	Question Number	Comment

THIS SUPPLEMENTAL APPLICATION WILL BE ATTACHED TO AND BECOME A PART OF THE POLICY.

The undersigned applicant hereby represents to Galen Insurance Company (the "Company") that all statements and explanations contained in this supplemental application and all attachments are true, complete and accurate, and that the applicant has not withheld any information that is reasonably likely to influence the judgment of the Company in considering this supplemental application for professional liability insurance. The applicant agrees to notify the Company of any change in the information contained in this supplemental application or any attachment if the change occurs while this supplemental application is under review or after coverage begins, if a policy is issued. The applicant further agrees to be bound by, and subject to, the underwriting guidelines, policies and procedures of the Company.

Acceptance of advance payment does not bind the Company to provide insurance.

The applicant acknowledges that he or she is responsible for payment of all unpaid premiums regardless of whether anyone has agreed to pay premiums on its, his or her behalf.

The applicant understands and acknowledges that upon acceptance of this supplemental application by the Company, this supplemental application will become a part of the policy and operate as part of a contract between the applicant and the Company. The applicant also understands and acknowledges that any misstatement or omission by the applicant or anyone for whom coverage is being sought, or any failure by the applicant or anyone for whom coverage is being sought to cooperate fully with Company will, in the discretion of the Company, result in the exclusion of a related claim from coverage under the policy and that under such circumstances the Company will not pay damages or claim expenses nor provide a defense to such a claim. In addition, such misstatements or failure to cooperate may result in cancellation of the policy.

The applicant hereby acknowledges that he or she has completed the required reporting of incidents and claims to the applicant's current insurer.

The applicant hereby represents that he or she has listed all claims, suit and incidents known to the applicant, or of which he or she should reasonably be aware, which would arise from the applicant's acts or omissions which have occurred in the past ten years.

INSURANCE COVERAGE IS SUBJECT TO UNDERWRITING APPROVAL AND FULL PAYMENT OF THE PREMIUM. NO COVERAGE EXISTS UNTIL THE PREMIUM IS FULLY PAID AND RECEIVED AND A DECLARATION PAGE, TOGETHER WITH ANY ENDORSEMENTS THAT MAY APPLY, HAVE BEEN ISSUED TO THE POLICYHOLDER.

I understand this information becomes a part of my application for professional liability insurance.

Print Name of Applicant:_____

Signature _____ Date _____

Print Name of Policyholder:_____

An underwriter may contact the applicant for further information or clarification.

AUTHORIZATION FOR RELEASE OF INFORMATION

The undersigned hereby authorizes Galen Insurance Company and its affiliates, agents and representatives (the "Company") to make inquiries, investigate and consult with all persons, places of employment, educational institutions, malpractice insurance carriers, state licensing boards, or other similar government and non-governmental entities or persons who may have information bearing on the undersigned's moral, ethical and professional reputation and qualifications, training and competence to carry out the practice of medicine. The undersigned authorizes release of such information and copies of related records and documents to the Company.

The undersigned authorizes the Company to disclose to such persons, employers, institutions, boards or agencies any information about the undersigned or its, his or her practice or business that the Company determines to be necessary or appropriate in making its investigations and inquiries.

The undersigned releases from liability and holds harmless all persons who provide information to the Company in good faith and without malice in response to such investigations and inquiries, and releases from liability and holds harmless the Company for all information disclosed by the Company in good faith and without malice in making such investigations and inquiries.

The undersigned agrees that a photocopy or facsimile of this authorization will serve as if it were the original.

_____ _____

Signature Date

_____

Printed Name

Galen Insurance Company

Form A - Claim/Incident Report

Please complete for each suit, claim or incident for which you responded yes in Question 15 of Part V of the supplemental application. Please provide complete details in order to allow proper evaluation without requesting additional information. Attach copies of patient's charts, operative notes, or other documents as appropriate.

1. Name of patient:_____ Age:_____ Sex:_____

2. Type: ☐ Incident ☐ Request for records ☐ Demand for money or services ☐ Suit.

3. Date of incident:_____ Date Notified:_____ Location of incident:_____

4. Date Reported to Insurer:_____ Name of Insurer:_____

5. Allegation:_____
   _____
   _____

6. Condition/diagnosis at time of incident:_____
   _____

7. Dates/description of treatment rendered:_____
   _____

8. Other physicians, professionals or entities involved:_____
   _____

9. Disposition of claim:
   - ☐ Suit threatened, no action taken
   - ☐ Suit filed but dropped by claimant
   - ☐ Closed without payment
   - ☐ Summary judgment in your favor
   - ☐ Court outcome in your favor - ☐ jury verdict ☐ directed verdict
   - ☐ Court outcome in favor of plaintiff - ☐ jury verdict ☐ directed verdict, $_____ verdict amount
   - ☐ Settled out of court
     Date Claim Paid:_____
     Amount paid on your behalf: $_____
     Did you wish settlement of the claim? ☐ Yes ☐ No
   - ☐ Open - Status Pending: ☐ awaiting mediation/arbitration or ☐ awaiting court action
     Reserve Amount: $_____

I understand this information becomes a part of my application for professional liability insurance.

Print name:_____ Date:_____

Signature:_____