



TO BE COMPLETED BY NURSE ANESTHETIST

APPLICATION FOR DESIGNATED EMPLOYEE COVERAGE: Nurse Anesthetist

(All statements below must be completed and all questions answered completely)

DO NOT CANCEL YOUR PRESENT INSURANCE UNTIL A BINDER LETTER HAS BEEN RECEIVED.

1. Name _____ Phone No. (____) _____

2. Name of Employer _____

3. Mailing Address _____
(Address of Employer)

4. I request an effective date of 12:01 A.M. _____, 20 _____

5. ARNP/Nurse License No. _____ Date Issued _____

6. Date employed _____ Birth date _____ Birth Place _____

7. EDUCATION

(a) RN Training

Name of Hospital	City & State	Dates: From	To

(b) Anesthesia Training:

Where	What Type	Dates: From	To

(c) Additional Training:

Where	What Type	Dates: From	To

8. What is the name of your last professional liability insurer, policy number and expiration date?

9. Have you ever been involved in a malpractice claim or suit either directly or indirectly? _____

(Complete supplemental claims information form on each claim suit.)

10. Have you ever had Professional Liability Insurance refused, declined, cancelled or accepted on special terms?

If Yes, give details: _____

11. PREVIOUS WORK EXPERIENCE

Employer	Address	Dates Employed

12. The foregoing answers and statements are complete and correct to the best of my knowledge and belief.

_____ Date

_____ Signature of Nurse Anesthetist

_____ Date

_____ Signature of Employer