



PROFESSIONAL LIABILITY ASSOCIATION
RISK RETENTION GROUP, INC.

EMERGENCY MEDICINE SUPPLEMENT

1. Indicate location and hours per week you engage in emergency medicine:

- a. Physician's office Hours: Name of facility:
b. Minor emergency center Hours: Name of facility:
c. Hospital emergency room Hours: Name of facility:
d. Major trauma center Hours: Name of facility:
e. Other (describe thoroughly) Hours: Name of facility:

Please describe your protocols for the transfer of patients:

2. Do you admit any of the following patients to a hospital, psychiatric facility, or surgicenter?

- a. Pediatric b. Medical
c. Obstetric d. Surgical

Describe your involvement in treatment and follow-up of the above patients:

3. Do you assume any responsibility for patients after they are admitted to the hospital other than emergent resuscitative situations?

Yes No

If yes, please describe:

4. Do you have 24-hour specialty or subspecialty back-up in your emergency room setting?

Yes No

If not, describe your disposition of patients:

5. Do hospital bylaws or emergency centers where you will be working permit you to initiate thrombolytic therapy?

Yes No

6. Do you assist in surgery?

Yes No

During your shift?

Yes No

Physician's Signature

Date

It is important that you keep us informed of any changes in your practice so that we can provide you with adequate coverage.