



PROFESSIONAL LIABILITY ASSOCIATION
RISK RETENTION GROUP, INC.

PROFESSIONAL LIABILITY APPLICATION FOR PERFUSIONISTS

Applicant Name: _____

Mailing Address: _____

City **County** **State** **Zip Code**

Location Address: _____

City **County** **State** **Zip Code**

Telephone: (____) _____ **Facsimile:** (____) _____

Person to contact for survey: _____

Name **Title**

The Applicant is: _____ **An Individual** _____ **Employee (W-2)**
 _____ **Independent Contractor (1099)**
 _____ **Sole Practitioner** _____ **Sole Proprietorship**
 _____ **Corporation** _____ **Partnership**
 _____ **Limited Liability Company**
 _____ **Other (describe):** _____

Proposed Effective Date:

Describe the nature of applicants operations, including types of services rendered and activities conducted: _____

List all hospitals/healthcare facilities where applicant provides professional services:

Enclosed copies of all contracts for providing professional services with hospitals/healthcare facilities or physician practice.

If applicant is an employee or independent contractor, list the names, addresses and nature of operations (e.g. hospital, perfusion service company, physicians practice) for each employer and/or person or organization to which you contract your services.

Enclose a copy of your letterhead, brochures, advertising materials.

Professional Staff:

	No. of Principals	No. of Employees	No. of Independent Contactors
a). Perfusionists	_____	_____	_____
b). Perfusion Assistants	_____	_____	_____
c). Autotransfusionists	_____	_____	_____
d). Others: Describe	_____	_____	_____

Does the applicant supervise any professional other than listed above?

- Yes. If yes, on a separate sheet provide a detailed explanation of responsibilities and relationship to the entity which employs these individuals. Also, indicate by profession the number of individuals supervised.
- No.

Are all perfusionists certified by the American Board of Cardiovascular Perfusion?

- Yes.
- No. If no, enclosed a complete curriculum vitae for each non-certified perfusionist and advise if "eligible" for certification by ABCP or the reason ineligible.

EXPOSURES:

	Previous 12 months	Estimated Next 12 Months
Annual Gross Receipts	_____	_____
Annual Number of Perfusionists Services Rendered:	_____	_____
Annual Number of Autotransfusion Services Rendered:	_____	_____
Annual Number of Other (list) Professional Services Rendered:	_____	_____

Service:

PRIOR ACTS CLAIMS AND INSURANCE:

Has the applicant provided professional services other than those that are currently being provided and which are disclosed in this application?

Yes. If yes, please describe: _____

No.

Has the applicant, including employees and independent contractors, ever had his/her license or certification revoked or suspended, been the subject of any disciplinary proceeding, or ever been reprimanded by any administrative agency, professional association or peer committee?

Yes. If yes, please explain: _____

No.

Has the applicant been contacted by an attorney either requesting records of a case in which there were suspected injuries or advised that a malpractice action is being investigated or contemplated?

Yes. If yes, please explain: _____

No.

Have any claims been made or occurrences reported against the applicant or any of the proposed insureds or against any entity in which any proposed insured has or has had an interest?

Yes. If yes, please describe and indicated status of the claim or suit, and any amounts paid or reserved, attaching additional sheets as necessary.

No.

Have any of the following incidents or circumstances occurred in applicants practice or service (performed by the applicant, applicants employee or any contractor for whom applicant is responsible) in the time between the desired retroactive date and today, which could reasonably be expected to evolve into a claim?

a). Any unexpected death, organ failure or impairment, neurological or functional deficit, paralysis, or substantial disability?

- Yes.**
- No.**

b). Any incidence or suspected incidence of an embolus event?

- Yes.**
- No.**

c). Any incidence or suspected incidence of operative complications resulting from improper administration of drugs/medicines, blood products or anesthetic agent, via the profusion service?

- Yes.**
- No.**

If the response is “yes” to a, b, or c above, the applicant should IMMEDIATELY send notice of claim or circumstance likely to give rise to a claim to applicants current insurer and attach a copy herewith.

***IMPORTANT: Attach a copy of the Declaration Page or Certificate of Insurance of your most recent coverage.**

DECLARTIONS AND WARRANTIES:

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be used in reliance upon the representation made herein. I further understand and agreed that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance upon this application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness engage in the activities of my of my business including authorization to every person or entity, public or private, to release to the Company or its agents any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

If a policy is issued pursuant to this application, I agree to participate in and cooperate with risk management and loss control surveys and recommendations made therefore.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that the applicant has not withheld any information that is calculated to influence the judgment of the insurance company in considering this application.

Applicant/Title

Date

NOTICE

THIS POLICY IS ISSUED BY YOR RISK RETENTION GROUP. YOUR RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL THE INSURANCE LAW AND REGULATIONS OF YOUR STATE. STATE INSURANCE INSOLVENCY GUARANTY FUNDS ARE NOT AVAILABLE FOR YOUR RISK RETENTION GROUP.