



COOPERATIVE OF
AMERICAN PHYSICIANS

**APPLICATION FOR NON-PHYSICIAN HEALTHCARE
PRACTITIONER (NPHP) COVERAGE**

This portion is to be completed by the Member/Physician Applicant / Entity/Medical Group Administrator:

As an authorized person of this medical practice, I hereby request that Mutual Protection Trust (MPT) provide medical professional liability coverage pursuant to the MPT Agreement, Part 1, to the person for whom this application is being submitted and who is employed by or related to the practice of:

_____ or _____
(Member/Physician Applicant Name) (Entity/Medical Group Name)

The Non-Physician Healthcare Practitioner may be referred to as "Worker." MPT uses the term, "Worker," to refer to an actual employee or independent contractor or agent.

EXISTING MEMBER OR ENTITY/GROUP? Yes No

Membership # _____ or Covered Entity # _____

Date of coverage (effective date) requested for the NPHP: ____ / ____ / ____

Date of retroactive coverage requested for the NPHP: ____ / ____ / ____

The retroactive coverage period must be related to the practice of the Member/Physician Applicant or Entity/Medical Group identified above. **A copy of a current declaration of coverage showing the retroactive coverage date must accompany this application for coverage.**

Limits of liability desired: Shared \$1M/\$3M Separate \$1M/\$3M*
 Shared \$2M/\$4M

*Separate limits are not available for all NPHPs.

How many hours does this NPHP work per week? _____

Name of office contact person for employment matters: _____

Phone Number: (____) _____

Fax Number: (____) _____

Email: _____

PERSONAL INFORMATION

1. Name: _____ 2. Job position: _____
3. Area of specialization: _____
(i.e., pediatrics, obstetrics, etc., if applicable)

NOTE: Please attach a copy of the NPHP's curriculum vitae (CV) to this application for coverage.

4. Primary Office Location _____ Secondary Office Location _____
- _____
- Office Phone: () _____ Office Phone: () _____

5. Is the NPHP licensed, certified, or registered by a national or state agency? Yes No
- If yes, license/certification/registration number: _____

6. Has any disciplinary action ever been taken against the NPHP's certification, licensure, or registration? Yes No
- If yes, please explain: _____

7. Has the NPHP ever been accused of having sexual relations with a patient or of treating a patient while under the influence of drugs and/or alcohol? Yes No
- If yes, please explain: _____

8. Is the NPHP currently in compliance with all continuing education requirements imposed by law for license, certificate, or registration renewal? Yes No

CLAIMS INFORMATION

1. Has the NPHP ever had a medical malpractice claim filed against him/her? Yes No
- If yes, please complete a Claim report form (page 7) for each Claim that has been made against you.

2. Are you aware of any incidents involving an injured patient in which the NPHP rendered care or treatment or was involved in any way that may result in litigation? Yes No
- If yes, please complete a Claim report form for each Claim or incident.
If additional forms are needed, please make copies or request additional forms from MPT.

PRACTICE INFORMATION

1. How many patients does the NPHP see per day? _____ Per week? _____
2. Are all of the patients seen by the NPHP patients of the Member(s)/Physician Applicant(s) /Entity? Yes No
If no, please explain the NPHP's separate practice. _____

3. Who is/are the NPHP's supervising physician(s) (if applicable)? _____

4. Is there a protocol or set of standardized procedures followed in the medical practice that has been agreed upon between the NPHP and the employer/supervising physician? Yes No

5. Does the NPHP have hospital privileges? Yes No
If yes, does she/he admit patients? Yes No
Discharge patients? Yes No

6. List the hospitals/facilities at which the NPHP has privileges.

<u>Hospital/Facility Name</u>	<u>City</u>	<u>Extent of Privileges</u>
_____	_____	_____
_____	_____	_____

7. Does the NPHP perform: major surgery Yes No
 minor surgery Yes No
If yes, please explain, including types of surgeries: _____

8. Does the NPHP assist any physicians in surgery? Yes No
If yes, at what type of surgeries does she/he assist? _____

9. Is the NPHP certified as first assistant? Yes No

10. Does the NPHP perform elective cosmetic procedures other than the use of pharmaceuticals to treat the epidermal layer of the skin? Yes No
If yes, please list procedures performed: _____

PRACTICE INFORMATION
FOR NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS ONLY

IMPORTANT FOR ALL NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS: MPT will not grant medical professional liability coverage unless a copy of the applicable written protocol between the supervising physician and the nurse practitioner (Standard Procedures) or physician assistant (Delegation of Services Agreement) is on file in the employer's medical office.

All nurse practitioners and physician assistants are required to attend CAP's Risk Management Program within ninety (90) days of the effective date of their medical professional liability coverage through MPT. A schedule will be sent with our approval letter if this application is approved.

1. Does the nurse practitioner/physician assistant see patients in any other setting under the Member's supervision, e.g., nursing home, other out-patient office/clinic? Yes No
If yes, please list: _____

2. How does the Member supervise the nurse practitioner/physician assistant's patient care?
 - a. Exam of the patient the same day as care is provided? Yes No
 - b. Chart review and countersign charts at a later time? Yes No
 - c. Delegated in Standardized Procedures or Delegation of Services Agreement? Yes No

3. Does the NP/PA furnish/order medication? Yes No
If yes, the formulary and/or types of medications permitted to furnish should be addressed in the written protocol.

4. If furnishing, please provide furnishing number (for NPs only): _____
If furnishing controlled substances, provide DEA number: _____

5. Does the nurse practitioner/physician assistant provide prenatal services? Yes No
If yes, up to what week? _____

6. Does the nurse practitioner/physician assistant attend or assist at deliveries? Yes No

CLAIM REPORT

(Photocopy as Needed)

1. Name of patient: _____ 2. Age: _____ 3. Sex: _____

4. Name of primary treating physician: _____

5. Relationship to patient _____

6. Date of Incident: ____ / ____ / ____ 7. Location: _____

8. Insurance Carrier: _____ 9. Other Defendants: _____

10. Present Status: Open Closed ____ / ____ / ____
Date

Incident Only 90 Day Notice Suit Filed Suit Served Arbitration

Method of Closing:

Dismissed

Defense Verdict

Settled – Amount paid on your behalf: \$ _____ Total Settlement: \$ _____

Judgment – Amount paid on your behalf: \$ _____ Total Judgment: \$ _____

11. Patient's allegations or other circumstances: _____

12. Condition and diagnosis at time of incident: _____

13. Dates and description of treatment rendered: _____

14. Condition of patient subsequent to treatment (and dates of follow-up treatment): _____

I understand that MPT will not provide medical professional liability coverage for Claims against me arising out of Professional Services rendered to the above-named patient.

Signature of NPHP

Date Signed

IMPORTANT NOTES

- If medical professional liability coverage is provided to this NPHP, it will only apply to Professional Services provided for the practice of the Member or Entity/Medical Group identified on page 1 of this application. MPT will not provide any coverage for Claims that arise out of acts, errors or omissions of the Worker that are outside of the course and scope of that person's duties as an employee, independent contractor or agent of the Member/Covered Entity.
- MPT reserves the right to discontinue coverage for this NPHP with advance notice to the Member/Covered Entity.
- **Existing Member:** Until this application is approved, MPT will not provide any coverage to the Member(s) or the NPHP for any Claim based on any act, error, or omission of the NPHP.
- **Worker: By my signature below, I hereby authorize CAP to contact my employers for references as needed.**

REPRESENTATIONS AND WARRANTIES

Each of the undersigned represents, warrants and understands the following:

MPT will not provide any coverage for Claims based on the acts, errors or omissions of the NPHP that took place before the approval date of this application, unless the NPHP is granted retroactive coverage.

We hereby warrant the truth, accuracy, and completeness of all statements contained in this application. We understand that MPT will rely upon these statements and answers in making its decision to approve or deny this application. No facts, events, acts, errors, omissions or circumstances known to the Member/Physician Applicant, Entity/Medical Group, and/or NPHP have been withheld from the responses to the questions in this application. We understand that if any facts have been withheld there will be no medical professional liability coverage for any Claim whatsoever and my coverage through MPT may be rescinded. We agree to notify MPT within thirty (30) days of any change to the information we have provided in this application.

The application for a Non-Physician Healthcare Practitioner Coverage, if approved, will be incorporated by the reference into the MPT Agreement, and we agree to be bound by all the terms and conditions of the MPT Agreement.

This application is deemed part of your membership in the Cooperative of American Physicians, Inc. (CAP) and medical professional liability coverage through MPT. If approved, it is incorporated into such by this reference.

Signature of Member/Physician Applicant/ Authorized Representative

Date

Signature of Worker

Date