



## PSYCHIATRISTS QUESTIONNAIRE

**NOTICE TO APPLICANT:** THE COVERAGE FOR WHICH YOU ARE REQUESTING WILL APPLY ONLY TO CLAIMS ARISING WHILE IN THE COURSE OF YOUR EMPLOYMENT FOR THE NAMED INSURED.

### SECTION I - GENERAL INFORMATION

(Please type or print)

1. Applicant Name:
  2. Mailing Address:
  3. Phone: Fax:
  4. Website: www. E-Mail:
- Note:** All insurance documents, premium invoices and correspondence will be mailed to this address.
5. Social Security Number: Date of Birth:
  6. Current Medical Licenses State / Number:

### SECTION II - EDUCATION AND TRAINING

1. Name and Location of Medical School Granting Degree:  
 Medical School Name:  
 City: State: County:  
  
 If you are a graduate of a non-US medical school, have you obtained an ECFMG Certificate? Yes      No
2. Are you Board Certified in any of the following specialties?
 

General Psychiatry	Yes	No	Date Attained:
Child & Adolescent Psychiatry	Yes	No	Date Attained:
Geriatric Psychiatry	Yes	No	Date Attained:
Administrative Psychiatry	Yes	No	Date Attained:
Other (Specify):	Yes	No	Date Attained:
3. Have you successfully completed any of the following post-graduate training, accredited by either the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons, Canada (RCPSC)?
 

General Psychiatry Residency	Yes	No	Date Attained:
Child & Adolescent Psychiatry	Yes	No	Date Attained:
Neurology Residency	Yes	No	Date Attained:
4. Have you successfully completed any of the following other post-graduate fellowships?
 

Forensic Psychiatry	Yes	No	Date Attained:
Geriatric Psychiatry	Yes	No	Date Attained:
Consultation/Liaison Psychiatry	Yes	No	Date Attained:
Addictionology	Yes	No	Date Attained:
Psychiatric Research	Yes	No	Date Attained:
Other (Specify):	Yes	No	Date Attained:
5. Have you successfully completed psychoanalytic training? Yes      No  
**If Yes:** Date Attained:  
 Average weekly # of **total practice** hours:  
 Average weekly # of **psychoanalytical** hours:  
 Average weekly # of **psychoanalytical** patients:

6. Have you participated in any Risk Management Seminar(s) during the last 12 months? Yes    No  
**If yes**, please attach a copy of the certification and brochure explaining the content of the seminar.

**SECTION III - INSURANCE AND PROFESSIONAL HISTORY**

1. Have you ever been denied professional liability insurance coverage? Yes    No  
**NOTE: MISSOURI APPLICANTS DO NOT RESPOND**  
**If yes**, please attach a separate sheet containing a complete explanation.
2. Has your professional liability insurance coverage ever been cancelled or refused renewal? Yes    No  
**NOTE: MISSOURI APPLICANTS DO NOT RESPOND**  
**If yes**, please attach a separate sheet containing a complete explanation.
3. Has your application (new or renewal) for professional liability insurance coverage ever been accepted subject to any conditions or restrictions? Yes    No  
**If yes**, please attach a separate sheet containing a complete explanation.
4. **Prior Insurance:**  
 List insurers or your employers' Insurers for the past ten (10) years. Attach additional pages as needed

Insurance carrier	Policy Period	Limits of Liability	Coverage Type (Occurrence/Claims-Made)

5. **Practice Locations:** List ALL locations at which you have practiced in the last ten (10) years. **Explain any gaps in time.**

Name of Practice	City	State	From (MM/YY) To (MM/YY)

**SECTION IV - COVERAGE REQUEST**

1. **Type of Coverage:**  
 Occurrence  
 Claims-Made \* **Requested Retroactive Date** (All States):  
**Note:** \*See PRIOR ACTS Supplemental Application.
2. If you checked off claims-made, please check the appropriate box below:  
 I have purchased the Extended Reporting Period Endorsement on my prior policy.  
 Name of carrier:  
  
 I understand that I elected not to purchase the Extended Reporting Period Endorsement on my previous claims-made policy, and I also have elected not to purchase the prior Acts Coverage on my new policy. I understand that I will be uninsured for the period in which my prior claims-made policy existed. Furthermore, I understand that because of this there will be a gap in my insurance coverage.

3. **Type of Practice:**  
 Psychiatry  
 Neurology without procedures  
 Neurology WITH procedures (including but not restricted to angiograms, arteriograms, myelograms, and pneumoencephalograms, CAT scans and NMR imaging)
4. **Hours of Practice:**  
 Full Time (over 20 hours per week of ALL covered professional activities and locations)  
 Part-Time (20 hours or less per week of ALL covered professional activities and locations)

**SECTION V - PRACTICE LOCATIONS**

Please complete a section for **EACH** practice location. Copy this page for additional locations as needed.

**Entity Name:**

**Street Address:**

**City:**

**State:**

**Zip:**

**County:**

**Telephone:**

**Fax:**

**Average weekly practice (in hours):**

**Average Number of patients per week:**

This location is a:

Detention Facility (Jail, Prison, Home for Juveniles, half-way houses for those convicted of or awaiting trial or criminal charges, or institutions for the treatment and confinement of those found "not guilty by reason of insanity", " guilty but mentally ill", etc.)

For-Profit Hospital, Clinic or Nursing Home

Not-For-Profit Hospital, Clinic or Nursing Home

Other (Specify):

- |   |     |                   |
|---|-----|-------------------|
| 1.) Do you serve as the Medical Director or Chief of Psychiatry at this location?   | Yes | No                |
| 2.) If this is a hospital or institution, is it accredited by a nationally recognized accreditation organization?                       | Yes | No                |
| 3.) If this is a hospital or institution, has it ever lost accreditation awarded by a nationally recognized accreditation organization? | Yes | No                |
| 4.) Do you teach at this location?  | Yes | No                |
| Classroom Teaching  |     | Clinical Teaching |

**Entity Name:**

**Street Address:**

**City:**

**State:**

**Zip:**

**County:**

**Telephone:**

**Fax:**

**Average weekly practice (in hours):**

**Average Number of patients per week:**

This location is a:

Detention Facility (Jail, Prison, Home for Juveniles, half-way houses for those convicted of or awaiting trial or criminal charges, or institutions for the treatment and confinement of those found "not guilty by reason of insanity", " guilty but mentally ill", etc.)

For-Profit Hospital, Clinic or Nursing Home

Not-For-Profit Hospital, Clinic or Nursing Home

Other (Specify):

- |   |     |                   |
|---|-----|-------------------|
| 1.) Do you serve as the Medical Director or Chief of Psychiatry at this location?   | Yes | No                |
| 2.) If this is a hospital or institution, is it accredited by a nationally recognized accreditation organization?                       | Yes | No                |
| 3.) If this is a hospital or institution, has it ever lost accreditation awarded by a nationally recognized accreditation organization? | Yes | No                |
| 4.) Do you teach at this location?  | Yes | No                |
| Classroom Teaching  |     | Clinical Teaching |

**SECTION VI - PRACTICE PROFILE**

*(Please attach a separate sheet for any required explanations.)*

- |    |   |     |    |
|----|---|-----|----|
| 1. | Do you sign insurance or other reimbursement forms for patients where you have not participated in their care and treatment?<br><b>If yes</b> , please describe in what capacity (e.g., as a Medical Director) and indicate what your signature means on such forms:  | Yes | No |
| 2. | Do you have admitting privileges?<br><b>If no</b> , please describe your mechanism for handling your patients who may require immediate in-patient care:  | Yes | No |
| 3. | Do you create and maintain a psychiatric/medical record for each patient under your care?<br><b>If no</b> , please explain.   | Yes | No |
| 4. | Do you prescribe controlled substances?   | Yes | No |
| 5. | Do you obtain an informed consent, whether signed by patient or noted in chart, before prescribing, especially when prescribing neuroleptics?   | Yes | No |
| 6. | Do you write prescriptions for patients you have not clinically evaluated other than to cover for another colleague whose patient requires a minimal refill on existing prescription?<br><b>If yes</b> , please explain under what circumstances:   | Yes | No |
| 7. | Do you provide medication management for patients who see another professional (e.g., Ph.D., MSW) as their primary therapist and see you for medication management only?<br>For how many patients per week?<br>Do you periodically see the patient yourself?  | Yes | No |
| 8. | Do you regularly treat general medical conditions presented by your psychiatric patients?<br><b>If yes</b> , please indicate:<br>a) Average number of patients per week you provide treatment to:<br>b) Nature of the conditions you treat and the type of treatment you provide:   | Yes | No |
| 9. | Do you now practice any specialty other than psychiatry?<br><b>If yes</b> , check applicable specialty(ies) below and indicate % of practice:<br>General Practice:     %                             Pediatrics:     %<br>Family Practice:     %                             Other (Specify):                             % | Yes | No |

10. Have you ever practiced a specialty other than psychiatry or neurology? Yes No  
**If yes, specify:**

11. Do you advertise as a specialist\* in the evaluation and treatment of any of the following? Yes No  
 Borderline Personality Disorders Chronic Pain  
 Eating Disorders Childhood Sexual Abuse  
 Multiple Personality Disorders or Dissociative Disorders Sex Therapy

**\* Note: "Specialist" is indicated by 1) advertisements, 2) marketing materials, 3) letterhead, or 4) employment, contractual relationship or admitting privileges at any institution with a special interest in any of the above.**

12. Do you supervise any other psychiatrist or other mental health care providers specializing in the disorders/activities listed in #11? Yes No

13. Does your treatment include use of abreaction, rage, sodium amytal, sex or recovered memory therapies? Yes No  
**If yes, please explain the clinical details regarding this treatment.**

14. Does your practice include forensic activities, e.g., child custody and visitation; criminal responsibility; competence, civil and criminal; correctional psychiatry; juvenile justice and violence? Yes No  
 What is the percent of your total practice time devoted to this activity? %  
 On a separate sheet, please explain the exact type of forensic activities.

15. Do you communicate with patients via e-mail? Yes No  
 Please explain nature of communications in detail.

16. Does your practice include telemedicine activities, e.g., the transfer of data through electronic (video or computer) means in order to provide healthcare to patients who are geographically separated from the clinicians involved? Yes No  
 What is the percent of your total practice time devoted to this activity? %  
 On a separate sheet, please explain the exact type of telemedicines.

17. Do you engage in any clinical and/or pharmaceutical research? Yes No  
**If yes, does the sponsor agree in writing to indemnify you for such research activities?** Yes No  
**If no, please explain type and extent of such activities:**

18. Do you treat patients with unconventional therapy, i.e., treatment not considered to be mainstream psychiatric treatment? Yes No  
**If yes, please describe:**

## FRAUD STATEMENT

**DECLARATIONS REPRESENTATIONS:** I/We affirm that the information contained here and in any addendum is true to the best of my/our knowledge and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I/We hereby authorize the release of claim information any prior insurer to the Company or its representatives.

**NOTICE TO APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO NEW YORK APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

**NOTICE TO KENTUCKY APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME.

**NOTICE TO MINNESOTA AND OHIO APPLICANTS:** ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

**NOTICE TO NEBRASKA AND OKLAHOMA APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

**NOTICE TO PENNSYLVANIA APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO FLORIDA APPLICANTS:** ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

**NOTICE TO NEW JERSEY APPLICANTS:** ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

**NOTICE TO MAINE AND VIRGINIA APPLICANTS:** IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

**NOTICE TO OREGON APPLICANTS:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW.

**NOTICE TO DISTRICT OF COLUMBIA APPLICANTS:** "WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT."

**NOTICE TO NEW MEXICO APPLICANTS:** "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES."

**NOTICE TO TENNESSEE APPLICANTS:** "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

Insured Signature : \_\_\_\_\_ Date:  
Agent Signature: \_\_\_\_\_ Date:

**SECTION VII - CLAIMS HISTORY – SUPPLEMENTAL APPLICATION**

Full Name:

***IMPORTANT:*** This section must be completed in its entirety. **Any** malpractice claims or suits in which you have been involved in during the past seven (7) years must be reported. **Any** incidents or circumstances of which you are aware of that are likely to give rise to a claim must be reported. Provide copies of suit papers or claimant letters. If the claim is closed, provide copies of settlement or judgment documents or order of dismissal. If reporting more than one incident, suit or claim, photocopy this form for each.

**N/A** (Please proceed to the next section.)

1. Name of Patient:
2. Allegation/Incident:
3. Incident Date: Report Date:
4. Was suit filed? Yes      No
5. Jurisdiction?
6. Names of Co-Defendants: (N/A)
7. Insurance Carrier(s) covering claim:
8. Policy Period(s):
9. Final outcome of claim (*This information may be obtained by inquiry of your current or past insurer. Please note that you must personally contact your insurance carrier.*)

**Open:** (still pending) Indemnity reserve placed by insurer: \$  
Defense cost reserve placed by insurer: \$

**Closed:**  
Method of closing: Total Expenses:  
 Dismissed Amount of settlement or judgment: \$  
 Withdrawn Defense cost: \$  
 Judgment  
 Settlement

10. Please provide summary of clinical facts. Your summary must provide an adequate description of your care and treatment of the patient to allow proper evaluation. Please include the following: (Use additional sheets if necessary.)
  - a) Patient age and sex
  - b) Initial patient condition and diagnosis
  - c) Condition and diagnosis at time of incident
  - d) Dates and description of treatment rendered
  - e) Condition of patient subsequent to treatment
  - f) Copies of patient's records and progress notes as appropriate

\_\_\_\_\_  
 Physician's Personal Signature

Date

## SECTION VIII - PRIOR ACTS COVERAGE

**IMPORTANT:** Please read all of the following carefully. Should you have any questions, please contact your broker prior to completing any information on this page.

- This information must be completed in its entirety before you can be considered for Prior Acts Coverage.
- A complete copy of all professional liability insurance policies (including all Declaration Pages and Endorsements) you maintained during the policy period for which you're requesting Prior Acts Coverage must accompany your application for coverage.
- In addition, you are eligible for Prior Acts Coverage only if you maintained continuous Claims Made Professional Liability Insurance, with your own limits of liability, during the entire requesting Prior Acts Coverage Period.
- Prior Acts Coverage is optional and subject to separate underwriting approval. For your own protection, unless you are specifically notified by the Philadelphia Insurance Companies through its agent or broker that your request for Prior Acts Coverage has been approved, do not forfeit your right to purchase Reporting Endorsement Coverage ("tail" coverage) from your current carrier.
- If approved for Prior Acts Coverage, no coverage exists under the Philadelphia Insurance Companies Human Services Organization Professional Liability Coverage Form for any claim or conduct, circumstances, occurrences or accidents likely to give rise to a claim which are known to you or which should have been known to you on the date of your application.

*(Please print or type all requested information.)*

1. Full Name:
2. Requested Retroactive Date: (MM/DD/YY)
3. Changes in Practice: Describe any changes in your practice if different in any way from your practice as describes in this entire application. **Note that Prior Acts Coverage, if approved, will apply only to the practice of psychiatry.**
  
4. Practice History: If you practiced with other health care providers as an employer, in a formal professional partnership or professional corporation during the period for which you are requesting coverage, please list the entities and health care providers below.

Entity:

Health Care Provider:

From: To:

Note: Please review carefully the Fraud Statement - Declarations of the Application, which also applies to all information contained on this page.