



Hospitalist Supplement to Application for Medical Professional Liability Insurance

AZ CO NV UT (80915)

1. Residency completed? Yes No
Specialty? _____ From: _____ To: _____
2. Fellowship completed? Yes No
Specialty? _____ From: _____ To: _____
3. Board certified? Yes No
Name of Board? _____ Dt: _____
4. Describe all additional training and/or CME courses you have taken related to the duties and responsibilities of a hospitalist.

5. Do you practice as a hospitalist 100% of the time? Yes No
If Yes, please provide a description of your practice activity.
- _____
- If No, please indicate percentage as hospitalist. _____
- If No, please describe your other practice activities.

Average|estimated number of hours worked per week for all practice activities. _____

6. Please indicate the patient population you provide services to.
- Adult Medicine: Yes No Percentage _____
- Critical Care: Yes No Percentage _____
- Obstetrics: Yes No Percentage _____
- Pediatric: Yes No Percentage _____

7. As a hospitalist, do you provide in hospital coverage:
- For only patients of your own practice? Yes No
- For admitted patients that are not your existing patients or your practice group's patients? Yes No

8. Are you practicing as part of a hospitalist group? Yes No
If Yes, group name: _____

9. Please list all hospitals where you practice as a hospitalist and indicate whether you are employed or contracted.

Name of Hospital	Employed	Contracted
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>

10. Do you practice as a hospitalist at any other facilities in addition to the hospitals noted in question #9 (such as a nursing home)? Yes No

If Yes, please list all facilities, indicate the type of facility, and indicate whether you are employed or contracted.

Name of Facility	Type of Facility	Employed	Contracted
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

11. Please note your hospitalist practice structure.

- Shift Based (on site at hospital) Call Based, multiple hospitals
 Call Based, single hospital (not on site) simultaneously (not on site)
 Combination of above – Please explain

12. Is your hospitalist coverage availability at the hospitals and other facilities noted in questions #9 and #10, 24/7 (24 hours, 7 days per week) coverage? Yes No

If No, please explain: _____

13. What is your average patient volume|patient load per shift at each noted hospital/facility? per shift approximately: _____

14. Do you utilize non-physician healthcare providers (PA's, NP's, etc.) in the performance of your hospitalist duties? Yes No

If Yes, please explain. _____

15. Do you follow surgical patients? Yes No

16. Do you perform pre-op evaluations? Yes No

17. Do you provide the primary care physician with a written discharge summary for every patient within five days of discharge? Yes No

18. Do you document all communication with the primary care physician in the medical record? Yes No

19. Please describe the system that ensures you review and follow-up on all test results that arrive after the patient has been discharged.

20. Do you see any hospital patients that do not have a primary care physician? Yes No
If Yes, what arrangements are made for any follow-up care that may be needed?

21. Do you perform any non-patient care activities in your role as hospitalist? i.e. quality review activities, medical director duties, etc. Yes No

If Yes, please explain.

SIGNATURE OF APPLICANT

DATE

I certify that all statements in this application are true, material, and complete.

NAME