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Obstetrics Supplement to Application for Medical Professional Liability Insurance

AZ CO NV UT (80153)

Completion and submission of this supplement is being used for data collection and statistical purposes to help us better understand how obstetrical practice is evolving.

1. Please check one of the following that best describes your practice:
   - ☐ OB/Gyn (office based ob/gyn practice to include the performance of deliveries; prenatal care; performance of gynecological procedures and surgery; and obstetrics call)
   - ☐ Laborist only (perform deliveries only; no office-based practice; no prenatal care; no gynecological procedures or surgery)
   - ☐ Office based ob/gyn practice only (prenatal care provided; no deliveries performed; refer all deliveries to laborist; does include performance of gynecological procedures and surgery)
   - ☐ Other – please describe: _____
2. Please indicate the following:

   Total hours worked per month: _____
   Number of new patients per month: _____
   Average number of deliveries per month for the most recent year: _____
   Of this number, what percentage are High Risk: _____
   C-Section: _____
   Uncomplicated: _____
   Average number of gynecological procedures per month: _____
3. Do you utilize ancillary healthcare personnel (NPs; PAs; Nurse Mid-Wives (certified and/or lay); etc.) in your practice or do you support a midwife partnership at your hospitals? ☐Yes ☐No
   If yes, please explain how they are utilized, including whether or not they have any call responsibilities; indicate the number of personnel in each position; and indicate whether or not they are employed by you.
   _____
4. Please list all hospitals and any other facilities where you practice.

   Name of Hospitals and Other Facilities

   _____ _____
   _____ _____
   _____ _____
5. From the list below, please check those that apply to your practice:
   - ☐ Abortions – 1st trimester
   - ☐ Abortions – 2nd trimester
   - ☐ Abortions – 3rd trimester
   - ☐ Assisted Reproductive Technologies such as IVF, GIFT, etc.
   - ☐ Cosmetic Procedures – please describe on your letterhead
   - ☐ C-Sections
   - ☐ Gynecological Surgery
   - ☐ Home Deliveries
   - ☐ Hospital Deliveries
   - ☐ Multiple Births
   - ☐ Prenatal Care (all trimesters)
   - ☐ Refer all deliveries to laborist
   - ☐ VBAC's
6. Do you provide Obstetrical care involving women with: (a) severe chronic disease that may adversely affect pregnancy, (b) fetal abnormalities by ultrasonography, (c) genetic disorders identified by history, and (d) CDE (Rh) or other blood group

isoimmunization excluding ABO, Lewis? ☐Yes ☐No

7. Please complete the following section if you are currently practicing as a laborist only (refer to definition under question #1). If you are not, please proceed to the end of this supplement and include your signature and date.
   a. Are you practicing as part of a laborist group? ☐Yes ☐No
      If yes, name of group. _____
   b. Please note your laborist practice structure
      ☐Shift Based (on site at hospital);
      ☐Call Based, single hospital (not on site);
      ☐Call Based, multiple hospitals simultaneously (not on site);
      ☐Support a midwife partnership at your hospitals.
      ☐Combination of above – please explain.
      _____
   c. What is your average number of deliveries per shift? _____
   d. Do you cover only one hospital during any given shift? ☐Yes ☐No
   e. Does the hospital where you practice have 24-hour anesthesia coverage? ☐Yes ☐No
   f. Does the hospital where you practice have the resources to do an immediate emergency C-section per ACOG guidelines? ☐Yes ☐No
   g. Do you have a formal or written plan in place for timely consultation with subspecialties (including transfer arrangements to appropriate level facility) for high risk situations? ☐Yes ☐No
   h. Are you in house during your shift and do you remain within 5 minutes of the labor and delivery unit? ☐Yes ☐No
   i. Do you have a formal or written plan in place for additional coverage with a similarly qualified physician if you are tied up with a case and unable to respond to other emergencies? ☐Yes ☐No
   j. When handing off patients to another physician, do you review the patient's history, course and treatment plan with the oncoming physician? ☐Yes ☐No
   k. Do you introduce yourself to all patients for whom you are responsible and meet family members where possible? ☐Yes ☐No
   l. Do you obtain and utilize available prenatal records on each patient to perform a pertinent H&P when seen for the first time? ☐Yes ☐No
   m. Do you obtain written informed consent for both planned and unplanned? surgical interventions except when to do so would delay care? ☐Yes ☐No
   n. Do you document the treatment course and provide sufficient information for another clinician to assume continuity of the patient's care at any point in the course of treatment? ☐Yes ☐No
   o. Do you participate in the coaching/training of nurses and other patient care personnel in order to enhance patient care in the hospital where you practice? ☐Yes ☐No
   p. Do you dictate surgery/delivery notes within 24 hours? ☐Yes ☐No
   q. Do you have a plan for maintaining currency in the interpretation of fetal heart rate monitoring and the assessment and treatment of high risk pregnancy? ☐Yes ☐No

Please explain any "no" response to questions 7d-q above.

_____

_____ _____

SIGNATURE OF APPLICANT DATE

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

_____

NAME