APPLICANT'S INSTRUCTIONS:

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Application must be signed and dated by owner, partner or officer.
3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.
4. Please do not complete application earlier than 45 days before proposed effective date of coverage.
5. If you have a Curriculum Vitae (C.V.), please attach to application and check here ____.

(PLEASE TYPE OR PRINT IN INK)

1. APPLICANT INFORMATION

a. Full name of applicant (include professional degree) :

b. Principal Business Address:

Please attach list of additional locations.

c. Business Phone: (____) _____ Home Phone: (_____) _____

d. Date of Birth: _____ Place of Birth: _____

e. Social Security No.:

f. Are you a U.S. citizen? [ ] Yes [ ] No. If no, please indicate your status and the date of entry into the U.S.

g. Limits of liability requested:

(i) $_____each claim $_____aggregate $_____deductible

(ii) Effective Date (12:01 A.M.):

h. [ ] Solo practitioner (uninc.) [ ] Solo practitioner (inc.) [ ] Professional corporation [ ] Professional Association
[ ] Partnership [ ] Employee of _____
(Give Name of Employer)

i. If you practice other than as an employee OR an unincorporated solo practitioner ONLY:

(i) Please list the names of ALL your partners, your employees, or members of your professional association or corporation who practice medicine.

(ii) Formal corporate, association, partnership or business name.

(iii) Please attach a copy of your letterhead.

j. Please list the states in which you practice and provide your respective license numbers:

State	License Number

1. APPLICANT INFORMATION (CONTD).

k. Please list the hospitals where you are currently on staff and indicate the percentage of work at each hospital.

Hospital	Percentage of Work

l. Briefly describe the type and extent of your hospital privileges.

m. Are you "chief of" or the "head" of any hospital department? [ ] Yes [ ] No

n. Do you or the firm indicated in question 1(i) above own (either wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered? [ ] Yes [ ] No

If yes, please provide a detailed explanation specifically including the name, location, size, and number of beds.

2. APPLICANT EDUCATION

a. Please provide the name and address of the medical school(s) that you attended indicating the degree(s) received and the year they were attained:

b. If you graduated from a foreign medical school, are you certified by the Educational Council for Medical School Graduates? [ ] Yes [ ] No

If yes, please state the year of your certification and describe your medical degree.

c. Did you complete any residency programs? [ ] Yes [ ] No

If yes, please provide a detailed explanation specifically including the type of residency program, the dates of each program, and the location and facility where they were served.

d. Have you received any additional medical training? [ ] Yes [ ] No

If yes, please provide an explanation specifically detailing the type of medical training, where the training was received, and the time period in which it was obtained.

e. Are you American Board certified? [ ] Yes [ ] No

If yes, please indicate the medical specialty in which you are certified, your date of certification, and any recertification dates.

f. Please provide a detailed summary of where you have practiced your profession since completing your training:

g. Are you a member of any professional societies? [ ] Yes [ ] No

If yes, please provide information regarding your membership(s).

h. Have you participated in any continuing medical education program(s) within the past five (5) years? [ ] Yes [ ] No

If yes, please provide a detailed explanation.

i. Do you or the firm named in question 1(i) above own, operate, or provide professional services for any health care facility or business enterprise not already clearly described in this application? [ ] Yes [ ] No

If yes, please attach a detailed explanation.

3. APPLICANT PRACTICE

a. What is your medical or surgical specialty:

b. Do you limit your practice to the above specialty? [ ] Yes [ ] No

c. Do you have a sub-specialty? [ ] Yes [ ] No

If yes, please provide a detailed explanation.

d. Do you perform one or more of the following procedures? Please check all that apply and provide a detailed explanation for all items checked including the name and location of the offices, hospitals, or centers where the procedures are performed.

____ Endoscopic procedures (other than Sigmoidosopy or proctoscopy
____ Catheterization (other than swan-ganz, umbilical cord, urethral catheterization, or arterial line in a peripheral vessel)
____ Dilation and Curettage
____ Needle biopsies
____ Electroshock therapy or hypnosis
____ Arteriography
____ Lymphangiography
____ Myelography
____ Phenmoencephalography
____ Interventional radiology
____ Percutaneous transluminal angioplasty or embolization
____ Radiation therapy (including radium transplants
____ Cosmetic plastic surgery (cosmetic body contouring implantations, injections and/or blepharopigmentation)
____ Open reduction of fractures
____ Hysterectomies
____ Laparoscopic hysterectomies
____ Tonsillectomies
____ Adenoidectomies
____ Weight reduction surgery
____ Experimental research, surgical research, or experimental therapy in human patients
____ Sex change operations
____ Chemobrasion
____ Dermabrasion
____ Hair transplants or suturing of hairpieces
____ Mohn micrographic surgery
____ Acupuncture (for analgesia) or acupuncture anesthesia
____ Prenatal care and normal deliveries
____ Home deliveries
____ Supervise midwives
____ Radial keratotomy
____ Hexagonal keratotomy
____ Any minimal incision surgery
____ Surgery (other than incision of boils and superficial abscess or suturing skin and superficial fascia
____ Non-spontaneous abortions(1st or 2nd trimester)
____ Sterilization procedures
____ Spinal surgery (including chemonucleolysis and/or percutaneous lumbar discectomy)
____ Administer anesthesia (general spinal or caudal block)
____ Cholecystectomies
____ Laparoscopic cholecystectomies
____ Caesarian sections
____ Organ Transplantations
____ Other surgery _____

e. Do you perform surgery in your office? [ ] Yes [ ] No

If yes, please describe the surgical procedure.

f. Do you perform surgery in non-hospital facilities? [ ] Yes [ ] No

If yes, please indicate the facility and describe the surgical procedure.

g. Is general anesthesia administered for any of the surgeries performed in questions 3(e) and 3(f)? [ ] Yes [ ] No

If yes, please indicate whether the anesthesia is administered by you or by an anesthesiologist.

h. Do you assist in surgery either on your own patients or on the patients of others? [ ] Yes [ ] No

i. Do you perform any hospital emergency room care? [ ] Yes [ ] No

If yes, please provide a detailed explanation specifically indicating the approximate hours per month spent in emergency room care, whether it is a requirement for staff privileges, and whether this care is for only your own patients.

j. Does your practice include plastic surgery? [ ] Yes [ ] No

If yes, what percentage of the practice is devoted to traumatic surgery and cosmetic surgery.

k. Does your practice include weight reduction or control (other than by diet-exercise)? [ ] Yes [ ] No

If yes, please provide a detailed explanation including the percentage of patients that are specifically weight control patients, whether you dispense any drugs and the names of the drugs, and whether you use injections for weight control and a list of the drugs injected.

l. Does your practice include weight reduction or control (other than by diet-exercise)? [ ] Yes [ ] No

If yes, please provide a detailed explanation including the percentage of patients that are specifically weight control patients, whether you dispense any drugs and the names of the drugs, and whether you use injections for weight control and a list of the drugs injected.

m. (i) Please list the number and type of professional employees in your practice. If NONE, state none.

___Physicians (other than yourself)
___Nurse practitioners*
___Nurse anesthetists
___Surgeon's assistants*
___Physician's assistants*
___Other _____

*Describe duties in detail, including extent supervised, on separate sheet.

(ii) Are all of the above individuals licensed in accordance with applicable state and federal regulations? [ ] Yes [ ] No

If no, please attach a detailed explanation.

n. Do you practice in a surgicenter, abortion clinic, drug control clinic, emergi-center, extended hour walk-in clinic or birthing center? [ ] Yes [ ] No

If yes, please provide a detailed explanation including the location of the center.

o. What is your average patient load?

Please provide information for number of patients weekly and number of patients annually.

p. What is the average number of hours devoted to your practice each week:

q. Do you anticipate any changes in your practice within the next year? [ ] Yes [ ] No

If Yes, please explain.

r. What is the approximate gross annual income from your practice? (Please check one).

____less that $50,000
____$100,000 to $199,999
_____$200,000 or more (please estimate)
_____$ 50,000 to $ 99,999
_____$150,000 to $199,999
_____Other _____

s. Please list prior professional liability insurance carried for each of the past five (5) years. If NONE, state none.

Insurance Company	Limits of Liability	Premium	Inception Mo/Day/Yr.	Expiration Mo/Day/Yr.	Was this a Claims Made Policy Form? Yes	No	Retro Date

Please attach a copy of the declarations page from your most recent coverage.

t. Do you supervise any individuals other than your own employees? [ ] Yes [ ] No

If yes, please provide a detailed explanation of their responsibilities and the relationship to the entity which employs these individuals.

u. Please indicate by profession the number of individuals supervised.

Number	Type of Profession	Number	Type of Profession
_____	Physicians	_____	X-ray Technicians
_____	Laboratory Technicians	_____	Other _____

4. APPLICANT AFFILIATIONS

a. Are you in the employ of any individual, firm or corporation other than your own? [ ] Yes [ ] No

If yes, please provide a detailed explanation including details of your responsibilities.

b. Are you under contract to any individual, firm or corporation other than you own? [ ] Yes [ ] No

If yes, please provide a detailed explanation including details of your responsibilities.

(If your contract contains a hold-harmless agreement, a copy of the contract must be attached to this application).

c. Are you in the employ of, or under contract to, any governmental entity? [ ] Yes [ ] No

If yes, please provide a detailed explanation including details of your responsibilities.

d. Do you advertise your professional services in any manner (other than a simple listing in a telephone directory)? [ ] Yes [ ] No

If yes, please submit a copy of your advertisement.

e. Are you associated with any agency or organization that engages in advertising for, or solicitation of, patients? [ ] Yes [ ] No

If yes, please submit a copy of ALL advertisements.

5. CLAIMS

(Attach a detailed explanation for any "yes" answers).

a. Have you ever been the subject of investigative or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital, or professional association? [ ] Yes [ ] No

(Attach a copy of the Complaint and Consent Order, if applicable)

5. CLAIMS (CONTD.)

b. Have you ever been convicted for an act committed in violation of any law or ordinance. [ ] Yes [ ] No

c. Have you ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital, or professional association requested or required that you be evaluated for any alleged mental condition and/or alcohol or drug addiction? [ ] Yes [ ] No

d. Have you ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? [ ] Yes [ ] No

e. Have you ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms? [ ] Yes [ ] No

f. Have you ever failed any medical licensing or specialty organization examination? [ ] Yes [ ] No

g. Do you have any chronic physical illness or defect? [ ] Yes [ ] No

h. Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer? [ ] Yes [ ] No

If yes, complete a Supplemental Claim Information form.

i. Has any claim or suit for alleged malpractice been brought against you? [ ] Yes [ ] No

If yes, complete a Supplemental Claim Information form.

j. Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you? [ ] Yes [ ] No

If yes, please complete a Supplemental Claim Information form.

NOTICE TO APPLICANT: The coverage applied for is SOLELY AS STATED IN THE POLICY, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD unless the extended reporting period option is exercised in accordance with the terms of the policy.

Any person who knowingly defrauds any insurance company by filing an application for insurance containing any false information or concealing, for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is subject to criminal and civil penalties.

WARRANTY: I warrant to the Insurer, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy of insurance and deemed incorporated therein, should the Insurer evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to Shand Morahan & Company, Inc., Shand Morahan Plaza, Evanston, Illinois 60201.

Name of Applicant

Title (Officer, partner, etc.)

Signature of Applicant

Date

SIGNING this application does not bind the Applicant or the Insurer or the Underwriting Manager to complete the insurance, but one copy of this application will be attached to the policy, if issued.

Quaker Special Risk

a division of the Quaker Agency Inc.

APPLICANT'S INSTRUCTIONS:
1. Answer all questions. If the answer requires detail, please attach a separate sheet,
2. Supplement must be signed and dated by owner, partner or officer.
3. PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS SUPPLEMENT.
(PLEASE TYPE OR PRINT IN INK)

NOTE: This form is to be completed by Applicant who has been involved in any claim or suit or is aware of an incident which may give rise to a claim. COMPLETE ONE FORM FOR EACH CLAIM/SUIT OR INCIDENT.

1 Applicant Name_____

2. Claimant Name_____

3. Name of lndividual(s) at your firm/Company Involved in Claim: _____

4. Indicate whether:_____ Claim/Suit_____ Incident

5. Date of alleged error:_____ Date claim made against applicant:_____

6. Additional defendants:_____

7. Current Disposition of claim-
   [ ] DISMISSED (Action dropped without any payment to claimant or Statute of Limitations has expired)
   [ ]ABANDONED (no activity from claimant for over 3 years)
   [ ] WON by defense
   [ ] WON by claimant Total Paid $_____ Amount Paid on your behalf $_____
   Indicate whether : [ ] Court judgment, or [ ] Out of court settlement
   [ ]OPEN Claimant's settlement demand $_____
   Defendants offer for settlement? $_____ Insurer's loss reserve $_____

8. Name of Insurer:_____

9. Description of claim: (Provide enough information to allow evaluation, and use reverse side if additional space is required.)

a. Alleged act, error or omission upon which Claimant bases claim: _____

b. Description of cases and events:

c. Description of the type and extent of injury or damage allegedly sustained:

d. If a medical claim provide type of injury claimed:

[ ] Emotional Only [ ] Temporary Disability [ ] Death [ ] Cosmetic
[ ] Permanent Disability [ ] Other (describe)_____

IO. Explain what action has been taken by you to prevent recurrence of the same type of claim**.**

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same warranty and conditions.

_____ _____
Name of Applicant* Title

_____ _____
Signature of Applicant Date

*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete this insurance.

Quaker Special Risk a division of the Quaker Agency Inc.

APPLICANT'S INSTRUCTIONS

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. This is a mandatory form which must accompany a completed application and supplemental claim information form.
3. PLEASE READ THE STATEMENTS AT THE END OF THIS APPLICATION CAREFULLY.

(PLEASE TYPE OR PRINT IN INK)

1. NAME OF APPLICANT_____

2. APPLICANT HISTORY_____

	Yes	No
a. Are you aware of any act, error, omission or circumstance which could result in a malpractice claim or suit being made against you?	[ ]	[ ]
If Yes, has this been reported to a prior carrier?	[ ]	[ ]
SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such medical incident or threat of claim; have you attached the completed form?	[ ]	[ ]

b. To the best of your knowledge, have any of the following adverse results occurred in your practice in the last (5) years:	Yes	No
(i) Unexpected death (including stillbirths)?	[ ]	[ ]
(ii) Unexpected organ failure or significant neurological or functional deficit?	[ ]	[ ]
(iii) Failure to diagnose cancer or infection resulting in death or disability of patient?	[ ]	[ ]
(iv) Tear or perforation of an organ or body part during an invasive procedure, or unplanned removal of a normal organ or body part during an operative procedure?	[ ]	[ ]
(v) Suspicious or positive x-ray, Pap smear or mammogram where patient was not contacted?	[ ]	[ ]
(vi) Follow-up/emergency surgery, myocardial infarction or cerebral vascular accident within **48 hours** of your previous diagnostic treatment or surgery?	[ ]	[ ]
(vii) Complications from improper medication or improper dosage?	[ ]	[ ]
(viii) Pathological and/or operative report which do not match?	[ ]	[ ]
If yes to any of the above, has it been reported to a prior carrier?	[ ]	[ ]
If **you have NOT reported to a prior carrier, please attach an explanation.** **SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such adverse result;** have you attached the completed form?	[ ]	[ ]

c. Has any attorney contacted you (e.g., request for medical records) in connection with any patient that has NOT been disclosed to us?	[ ]	[ ]
If yes, **SUPPLEMENTAL CLAIM INFORMATION form SM6236 is required for each such adverse result;** have you aitached the completed form?	[ ]	[ ]
d. Does your current professional liability carrier require reporting of an incident or request for records by a patient or attorney?	[ ]	[ ]

	Yes	No
e. Has any prior professional liability carrier refused coverage for, or declined to accept your report of, a medical incident, threat of claim, adverse result or attorney contact'? If yes, please attach an explanation.	[ ]	[ ]

I understand information submitted herein becomes a part of my Professional Liability Application and is subject to the same warranty and conditions.

_____ _____

Name of Applicant* Title

_____ _____

Signature of Applicant Date

*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete the insurance.

Quaker Special Risk a division of the Quaker Agency Inc.

(FAX

NAME: Click here to replace text
COMPANY: Click here to replace text
ADDRESS: Click here to replace text
STATE, ZIP: Click here to replace text
DATE: Click here to replace text
NUMBER OF PAGES(incl. Cover): Click here to replace text
* FAX TO: Click here to replace text

PLEASE FAX THIS APPLICATION TO THE OFFICE THAT IS NEAREST YOU.

* Click the link below for a list of our offices and current fax numbers.

http://www.qsr-insurance.com/qsr-fax.html

ADDITIONAL COMMENTS:

Click here to replace text