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PREMIUM:  
RATED BY:  
EFFECTIVE DATE:  
RETRO DATE:  
REFUND AMOUNT DUE:

**RENEWAL APPLICATION FOR PSYCHIATRIC NURSE PRACTITIONER/PHYSICIAN ASSISTANT PROFESSIONAL/ADVANCE PRACTICE REGISTERED NURSE PROFESSIONAL AND BUSINESS LIABILITY INSURANCE COVERAGE**

Offered through the Professional Counselors Purchasing Group, Inc.

Notice to Florida Applicants:  
License # A127510 issued to Richard C. Imbert

Notice to Iowa Applicants:  
License # IA000000010776 issued to Richard C. Imbert

Notice to California Applicants:  
License #0555091 issued to American Professional Agency, Inc.

THIS APPLICATION IS FOR COVERAGE TYPE:  CLAIMS-MADE  OCCURRENCE-BASED

**NOTICE: THE COVERAGE OF A CLAIMS-MADE POLICY IS LIMITED GENERALLY TO LIABILITY FOR ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED, OR PROCEEDINGS FIRST BROUGHT, DURING THE POLICY PERIOD, AND REPORTED IN WRITING TO THE INSURER IN ACCORDANCE WITH THE TERMS OF THE POLICY. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE COVERAGE THEREUNDER WITH YOUR LEGAL OR INSURANCE ADVISOR.**

**NOTICE: A LOWER LIMIT OF LIABILITY APPLIES TO JUDGMENTS OR SETTLEMENTS WHEN THERE ARE ALLEGATIONS OF SEXUAL MISCONDUCT (SEE SECTION V. (C). “MAXIMUM LIMIT OF LIABILITY - SEXUAL MISCONDUCT” IN THE POLICY).**

- This Application must be completed in full, including all required attachments. Write “None” if that applies.
- Attach a separate sheet of paper if more space is needed to answer any question.
- We treat all Applications as confidential. If additional assurances of confidentiality are required, we are willing to address the Applicant’s needs.

**PLEASE READ THE ENTIRE APPLICATION CAREFULLY BEFORE SIGNING.**

**I. GENERAL INFORMATION**

1. a. Name of Applicant \_\_\_\_\_ Policy No.: \_\_\_\_\_

E-mail address: \_\_\_\_\_

b. Professional Designation (check one):  Nurse Practitioner  Physician Assistant  
 Advance Practice Registered Nurse

## II. APPLICANT INFORMATION

2. a. Principal Office Address: \_\_\_\_\_

\_\_\_\_\_  
(City) (County) (State) (Zip)  
Entity and/or Facility Name: \_\_\_\_\_

Note: If you have been practicing at this location fewer than 3 years, please provide us with your previous location on a separate sheet of paper and the length of time at that location.

b. Any Other Office Address: \_\_\_\_\_

\_\_\_\_\_  
(City) (County) (State) (Zip)  
Entity and/or Facility Name: \_\_\_\_\_

c. Home Address: \_\_\_\_\_

\_\_\_\_\_  
(City) (County) (State) (Zip)

d. If you are practicing in multiple locations which are located in different counties and/or states, please provide a percentage of time spent in each location.

3. To which of these addresses do you wish correspondence sent?  2a  2b  2c

4. Office Telephone: ( ) \_\_\_\_\_ Fax #: ( ) \_\_\_\_\_ Home Telephone: ( ) \_\_\_\_\_

5. a. Change in Policy Limits Requested? \_\_\_\_\_ / \_\_\_\_\_

b. Are you interested in obtaining limits higher than \$5,000 for defense expenses related to licensing board investigations and other proceedings as described in the Policy?  Yes  No

If yes, choose higher limit of liability desired for defense expenses related to licensing board investigations and other proceedings as described in the Policy:

- \$10,000 (Additional Premium \$75)  \$25,000 (Additional Premium \$95)  \$50,000 (Additional Premium \$110)  
 \$75,000 (Additional Premium \$171)  \$100,000 (Additional Premium \$232)  \$125,000 (Additional Premium \$293)  
 \$150,000 (Additional Premium \$354)

Please include the additional premium indicated with your premium payment.

## III. PRACTICE INFORMATION

6. Have any of your responses to Questions 7 through 16 below changed since your completion of the prior application for this coverage?

Yes  No

If yes, please respond to Questions 7 through 16 below.

If no, please go directly to Section IV. of this Application.

7. a. Name of physician or clinic you will be working for: \_\_\_\_\_

b. Policy No.: \_\_\_\_\_ Name of supervising physician: \_\_\_\_\_

c. Is your supervising physician a psychiatrist?  Yes  No

8. Desired effective date of coverage: \_\_\_\_\_ Number of hours worked per week: \_\_\_\_\_

9. Practice address: \_\_\_\_\_  
(street) (city) (state) (zip) (phone)

Entity and/or Facility Name: \_\_\_\_\_

10. Will you be working at the same location as your supervising physician?  Yes  No

If no, where will you be working? \_\_\_\_\_

11. Do you have a written collaboration agreement with your supervising physician?  Yes  No

How often will your charts be reviewed? \_\_\_\_\_

12. Do you have written protocols?  Yes  No

13. a. List your name and qualifications.

Name	Degree	Field of Study	Professional Association Membership		Number of hours practice each week	License or Certification			
			Association name	Membership Level		First Year Licensed	State	Title	Board Certified? Yes/No

**b. Please attach a copy of your Curriculum Vitae (C.V.).**

14. PRACTICE PROFILE

a. Composition of your practice: Children/Adolescents/Related Adults \_\_\_\_\_% Prisoners \_\_\_\_\_%

Adults (not related to above) \_\_\_\_\_% Sex Offenders \_\_\_\_\_% Custody Evaluation \_\_\_\_\_%

If your practice includes prisoners, is this a correctional facility?  Yes  No

If yes, is insurance coverage provided for these activities by such facility?  Yes  No

b. Do you have admitting privileges?  Yes  No

If no, please describe your mechanism for handling your patients who may require immediate in-patient care:

\_\_\_\_\_

c. Do you create and maintain a psychiatric/medical record for each patient under your care?  Yes  No

If no, please explain: \_\_\_\_\_

d. Do you have prescriptive authority?  Yes  No If yes, what Schedule? \_\_\_\_\_

If no, please provide the name and clinical specialty of the physician who will write prescriptions:

\_\_\_\_\_

e. Do you obtain an informed consent, whether signed by the patient or noted in the chart, before prescribing medication? Yes No

f. Do you regularly treat general medical conditions presented by your psychiatric patients? Yes No

If yes, please indicate: (1) Average number of patients per week you provide treatment to: \_\_\_\_\_

(2) Nature of the conditions you treat and the type of treatment you provide: \_\_\_\_\_

g. Do you advertise as a specialist\* in the evaluation and treatment of any of the following?

Borderline Personality Disorder Chronic Pain Multiple Personality Disorder or Dissociative Disorders

Childhood Sexual Abuse Eating Disorder 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.

h. 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. \_\_\_\_\_

i. 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.

j. Do you communicate with your patients via e-mail? Yes No

Please explain the nature of communications in detail. \_\_\_\_\_

k. 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 total practice time devoted to this activity? \_\_\_\_\_%

On a separate sheet, please explain the exact type of telemedicine activities.

l. Do you engage in any clinical trials and/or pharmaceutical research? Yes No

If yes, does the sponsor agree in writing to indemnify you for such research activities? \_\_\_\_\_

(Please include a copy of these indemnification agreements. )

If no, please explain type and extent of such activities: \_\_\_\_\_

m. Do you treat patients with unconventional therapy, i.e. treatment not considered to be mainstream psychiatric treatment? Yes No

If yes, please describe: \_\_\_\_\_

n. Do you cover any ER for crisis cover? Yes No

If yes, please indicate percentage of time devoted to this activity: \_\_\_\_\_%

Is this on call? Yes No

If yes, approximately how many hours per week? \_\_\_\_\_

15. a. Are you engaged in self-employment, paid consultation or private practice? Yes No

b. Are you employed (W2 form employee)? Yes No

If yes, employed by: \_\_\_\_\_

c. Are you a salaried employee of any organization other than the firm listed in Question 2a? Yes No

If yes, please explain: \_\_\_\_\_

d. Do you own, partly own, manage or exercise any form of fiduciary control over any business enterprise or medical practice? Yes No

If yes,:

i. Please explain the nature of the enterprise. \_\_\_\_\_

ii. Please provide a count of employees by type. \_\_\_\_\_

16. a. Are you on the staff of, or affiliated with, any hospital, clinic, group home or nursing home? Yes No

If yes, please list institution, nature of work and hours per week. \_\_\_\_\_

\_\_\_\_\_

b. Are you provided malpractice coverage by a facility or place of employment, or any other policy that covers you? Yes No

Yes No

If yes, please indicate location of the facility or place of employment and limits provided. \_\_\_\_\_

c. Do you have any direct or indirect financial interest in any hospital, pharmacy, diagnostic or therapeutic laboratory, nursing home, health service or any healthcare service to which you refer your patients? Yes No

Yes No

If yes, please specify and fully explain. \_\_\_\_\_

#### IV. PRIOR COVERAGE HISTORY

17. a. Do you currently carry your own separate, professional liability policy? Yes No

If yes, please include a copy of that declarations page with the completed application form.

Name of present carrier: \_\_\_\_\_

Number of years: \_\_\_\_\_

If less than 5 years, please list previous carrier as well: \_\_\_\_\_

b. Type of policy (if known): Occurrence Claims-made

c. Limits of present coverage: \_\_\_\_\_/\_\_\_\_\_

If prior professional liability insurance was on a claims-made basis, indicate the retroactive date of the coverage:

(Date after which wrongful acts are covered.) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

d. If you selected Claims-made in Question 12 b., please check the appropriate box below:

i. The Extended Reporting Period Endorsement has been purchased on my prior policy.  Yes  No  
If yes, please indicate the name of prior carrier: \_\_\_\_\_

ii. Prior Acts Coverage is requested on my new Claims-made policy.  Yes  No

If yes, please indicate Retroactive Date desired: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

(Please submit Declarations page for all individuals listed in Question 6.)

e. If you answered No to Questions 17 e. i. and ii., please review the statement and check the box below:

I understand that I elected not to purchase the Extended Reporting Period Endorsement on my prior Claims-made policy, and I also have elected not to purchase the Prior Acts Coverage on my new Claims-made 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.

**VI. REPRESENTATIONS**

18. a. Have you ever been convicted of a crime in any state or country?  Yes  No

If yes, please give full particulars in order for your Application to be considered. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

b. Have you ever had any licensing board or professional ethics body require the surrender of a license or found you guilty of a violation of ethics codes, professional misconduct, unprofessional conduct incompetence or negligence in any state or country?

Yes  No

If yes, please give full particulars and provide copies of charges, correspondence and any findings in order for your Application to be considered. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

c. Are there any complaints, charges or investigations pending against you by a licensing board or professional ethics body for violation of ethics codes, professional misconduct, unprofessional conduct, incompetence, or negligence in any state or country?

Yes  No

If yes, please give full particulars and copies of charges, correspondence and any findings in order for your Application to be considered. \_\_\_\_\_

\_\_\_\_\_

- d. Have you ever had any insurance company or Lloyd's decline, cancel, refuse to renew, or accept only on special terms any professional liability insurance?

Yes  No

**NOTE: MISSOURI APPLICANTS DO NOT RESPOND TO QUESTION 18d.**

If yes, please give full particulars in order for your Application to be considered. \_\_\_\_\_

\_\_\_\_\_

- e. Has any professional liability claim or suit ever been made against you?

Yes  No

If yes, please give full particulars and copies of any summons and complaints, pertinent correspondence and outcome, if any, in order for your Application to be considered.

\_\_\_\_\_

\_\_\_\_\_

- f. Are there any circumstances, including any loss of private or confidential information, which you are aware of that may result in any professional liability claim or suit being made against you?

Yes  No

If yes, please give full particulars in order for your Application to be considered. \_\_\_\_\_

\_\_\_\_\_

- g. Have you engaged in or ever been engaged in any sexual misconduct\* with any of your current or former patients or any current or former patient's spouse or any person with a direct relationship to the current or former patient (for example a guardian, blood relative of the patient or spouse or any person sharing the patient's domicile)?

Yes  No

(\*“Sexual misconduct” means any actual or alleged erotic physical contact or attempt, threat or proposal thereof.)

If yes, please give full particulars in order for your Application to be considered.

\_\_\_\_\_

\_\_\_\_\_

- h. Have you ever had any hospital restrict or revoke privileges or invoke probation for any cause?

Yes  No

If yes, please give full particulars in order for your Application to be considered.

\_\_\_\_\_

\_\_\_\_\_

i. Have you ever been suspended, restricted, or put on probation by any governmental health program (i.e. Medicare or Medicaid)?

Yes No

If yes, please give full particulars in order for your Application to be considered.

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j. Are you now being, or have you ever been, treated for a serious health problem that did or can impair your ability to treat patients?

Yes No

If yes, please give full particulars in order for your Application to be considered.

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## VII. NOTICES TO APPLICANT & FRAUD WARNINGS

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after diligent inquiry, the statements in this Application and any attachments or information submitted to or obtained by the Insurer in connection with this Application (together referred to as the "Application") are true and complete.

The information in this Application is material to the risk accepted by the Insurer. If a policy is issued it will be in reliance by the Insurer upon the Application, and the Application will be the basis of the contract. The Application is on file with the Insurer, and shall be deemed to be attached to, and made a part of, and incorporated into the Policy, if issued.

The Insurer is authorized to make any inquiry in connection with this Application. The Insurer's acceptance of this Application or the making of any subsequent inquiry does not bind the Applicant or the Insurer to complete the insurance or issue a policy.

If the information in this Application materially changes prior to the effective date of the Policy, the Applicant will immediately notify the Insurer, and the Insurer may modify or withdraw any quotation or agreement to bind insurance.

**NOTICE TO MARYLAND APPLICANTS:** "ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

INSURANCE POLICIES ARE SUBJECT TO A 45 DAY UNDERWRITING PERIOD BEGINNING ON THE EFFECTIVE DATE OF COVERAGE. IF THE INSURER DISCOVERS A MATERIAL RISK FACTOR DURING THIS PERIOD, THEN THE INSURER SHALL RECALCULATE THE PREMIUM PROVIDED THE RISK CONTINUES TO MEET ITS UNDERWRITING STANDARDS AND NOTICE OF THE RECALCULATED PREMIUM SHALL BE SENT TO THE INSURED. THE INSURER MAY CANCEL THE POLICY IF THE RISK DOES NOT CONTINUE TO MEET ITS UNDERWRITING STANDARDS, IN WHICH CASE NOTICE OF CANCELLATION SHALL BE SENT TO THE INSURED AT LEAST 15 DAYS PRIOR TO CANCELLATION.



**VIII. DECLARATION AND SIGNATURE**

*I understand that it is my obligation to maintain any license required in the jurisdictions in which I practice.*

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
(This application must be dated within 30 days of receipt) (APPLICANT / OWNER / PRESIDENT OF CORPORATION)

Title: \_\_\_\_\_

Application must be signed, dated, fully completed and accompanied by the premium to be considered.

**Please make checks payable and mail to: American Professional Agency, Inc.**

Program Administrator:  
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Producer Signature: