



## DirectorShield™ Application

Complete, flexible liability coverage for:

- Errors and Omissions
- Employment Practices Liability
- Professional Liability
- Regulatory Action Defense Cost

### Application Checklist

- Signed Application
- Certificate/verification of current insurance (Section I)
- Copy of service contract(s) (Section II)
- Copy of Dec Page or Cert of Insurance (Section III)
- Current CV

### Section I. Personal Information

#### APPLICANT PHYSICIAN INFORMATION

1. Applicant Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_
2. License # \_\_\_\_\_ Expiration Date \_\_\_\_\_ State \_\_\_\_\_ Year Licensed \_\_\_\_\_  
 Certification: \_\_\_\_\_
3. Current Practice: \_\_\_\_\_ (dates from \_\_\_\_\_ to \_\_\_\_\_)  
 Specialty: \_\_\_\_\_ Board Certified? \_\_\_\_\_  
 Type Practice:  Solo Practice  Partnership  Group Practice  Other: \_\_\_\_\_  
 Name of your practice group: \_\_\_\_\_  
 If you practice as EM physician, list hospital EDS where you serve:  

Name	City	State
4. Medical School: \_\_\_\_\_ Date Completed: \_\_\_\_\_ Degree: \_\_\_\_\_
5. Internship / Residencies:
6. Medical Center: \_\_\_\_\_ Dates Served: \_\_\_\_\_ to \_\_\_\_\_
7. Medical Center: \_\_\_\_\_ Dates Served: \_\_\_\_\_ to \_\_\_\_\_
8. Medical Malpractice Insurance – **attach certificate or other verification of current insurance.**
9. Claims Information: Has any claim or suit for alleged malpractice been brought against you in the last 5 years, or are you aware of circumstances that might lead to such a claim/suit?  Yes  No  
 If yes, describe event including claimant name, date of incident, suit status, amount of settlement or reserve (or attach separate sheet): \_\_\_\_\_  
 \_\_\_\_\_

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10. Sanctions: Has applicant ever had his/her license or certification revoked, suspended, or restricted, been subject to any disciplinary proceeding, been reprimanded by an administrative agency, professional association or peer committee:  Yes  No  
If yes, describe in detail: \_\_\_\_\_
11. Have you:
- Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital or professional association?  Yes  No
  - Ever been convicted for an act committed in violation of any law or ordinance other than traffic offense?  Yes  No
  - Ever been treated for alcoholism or drug addiction?  Yes  No
  - 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
  - Ever had any insurance company cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? (not allowed in MO)  Yes  No
  - Ever had your hospital privileges denied, modified, suspended, revoked, non-renewed or accepted on a restricted basis or been subject to probation, reprimand, censure, sanction or other disciplinary action as a result of a hospital committee investigation or inquiry?  Yes  No
  - Had any professional liability and /or Employment Practices Liability claims or incidents made against you, the applicant, or anyone proposed for this insurance?  Yes  No
  - Have you completed an EMS fellowship?  Yes  No  
If "Yes," please describe: \_\_\_\_\_
  - Have you completed the three-day NAEMSP course?  Yes  No
12. Have you completed any other EMS education? If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
13. What licenses do you carry that are EMS-related? (EMT-, NREMT-, CCTN, etc.)  
\_\_\_\_\_
14. Which of these certifications do you have?  ACLS  ATLS  PALS/APLS
15. Date you first became an EMS Medical Director: \_\_\_\_\_
16. Does your service contract require you to carry your own liability insurance?  Yes  No  
Type and limits required? \_\_\_\_\_
- Do you have other coverage for this position or contract?  Yes  No  
Please describe and attach declarations page of applicable insurance.  
\_\_\_\_\_

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17. Do you currently carry insurance as an EMS Medical Director?  Yes  No

If "Yes," please provide a copy of your Declarations Page or Certificate of Insurance

18. Do you as EMS Director **directly employ** EMS system personnel?  Yes  No

If "Yes," Please list them here:

Name	Prof. Designation	Explain Their Function

19. Do you write performance reviews on employees of the facility or system you serve?  Yes  No

20. Has any administrative action, hearing or grievance been filed against you?  Yes  No

If "Yes," how many? \_\_\_\_\_

If "Yes," please complete a Claim/Circumstance/Administrative Hearings Supplement for each incident.

21. Are you aware of any facts or circumstances that might give rise to a medical malpractice, professional liability, or Employment Practices Liability claim against you?  Yes  No

If "Yes," how many? \_\_\_\_\_

If "Yes," please complete a Claim/Circumstance/Administrative Hearings Supplement for each incident.

22. Have you been made aware of any charges, inquiries, investigations, grievances or other administrative or disciplinary hearings against you?  Yes  No

If "Yes," how many? \_\_\_\_\_

If "Yes," please complete a Claim/Circumstance/Administrative Hearings Supplement for each incident.

23. Have you ever been named in a professional services liability suit for other than medical professional liability?  Yes  No

If "Yes," please describe any such events here \_\_\_\_\_

\_\_\_\_\_

Was a settlement or jury verdict paid on your behalf?  Yes  No

If "Yes," what was the amount? \_\_\_\_\_

**Attach the Declaration Page or Certificate of Insurance providing proof of active professional liability coverage**

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**Section II. Facility or System Information**

**EMS SYSTEM INFORMATION**

Please complete the following for any EMS Directorships (facility or service) for which you seek coverage.

A. Name of System or Facility \_\_\_\_\_

Address \_\_\_\_\_

County \_\_\_\_\_ State \_\_\_\_\_

Phone \_\_\_\_\_ Fax# \_\_\_\_\_ Number of patients seen, or runs, per year \_\_\_\_\_

# of: EMT-B \_\_\_\_\_ EMT-I \_\_\_\_\_ EMT-P \_\_\_\_\_ other personnel under your supervision \_\_\_\_\_

Total = \_\_\_\_\_

If you ever actually treat EMS system patients please explain why and estimate the number of times per year that this occurs \_\_\_\_\_

**Attach a copy of your service contract**

B. Name of System or Facility \_\_\_\_\_

Address \_\_\_\_\_

County \_\_\_\_\_ State \_\_\_\_\_

Phone \_\_\_\_\_ Fax# \_\_\_\_\_ Number of patients seen, or runs, per year \_\_\_\_\_

# of: EMT-B \_\_\_\_\_ EMT-I \_\_\_\_\_ EMT-P \_\_\_\_\_ other personnel under your supervision \_\_\_\_\_

Total = \_\_\_\_\_

If you ever actually treat EMS system patients please explain why and estimate the number of times per year that this occurs \_\_\_\_\_

**Attach a copy of your service contract**

C. Name of System or Facility \_\_\_\_\_

Address \_\_\_\_\_

County \_\_\_\_\_ State \_\_\_\_\_

Phone \_\_\_\_\_ Fax# \_\_\_\_\_ Number of patients seen, or runs, per year \_\_\_\_\_

# of: EMT-B \_\_\_\_\_ EMT-I \_\_\_\_\_ EMT-P \_\_\_\_\_ other personnel under your supervision \_\_\_\_\_

Total = \_\_\_\_\_

If you ever actually treat EMS system patients please explain why and estimate the number of times per year that this occurs \_\_\_\_\_

**Attach a copy of your service contract**

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**Section III. Coverages and Limits**

**SELECT COVERAGE LIMITS**

**Errors and Omissions - Director's Liability**

Please Select a Limit:

- \$100,000/300,000       \$250,000/500,000       \$500/1M       \$1M/1M
- \$1M/2M       Errors and Omissions Liability not required

**Med Mal - Professional Liability for Alleged Negligence in Direct Patient Care**

Please Select a Limit:

- \$100,000/300,000       \$250,000/500,000       \$500/1M       \$1M/1M
- \$1M/2M       Malpractice Professional Liability not required

**Employment Practices and Workplace Liability - includes sexual harassment, wrongful termination**

Please Select a Limit:

- \$50,000/100,000       \$100,000/300,000       \$250,000/500,000       \$500/1M
- \$1M/1M       \$1M/2M       Employment Practices Liability not required

**Regulatory Action Defense Cost (for challenges to your license status as a result of a claim, grievance, administrative action against you as an EMS Medical Director.)**

Please Select a Limit:

- \$25,000/50,000       \$50,000/100,000       \$100,000/300,000       \$250,000/500,000
- \$500/1M       \$1M/1M       \$1M/2M
- License Defense Insurance not required

Other Required or Requested Coverage - type \_\_\_\_\_

Limits? \_\_\_\_\_

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**Section IV. Signature and Warranty**

**SIGNATURE SECTION AND OTHER INFORMATION**

**NOTE:** Please recheck all answers and sign below. Coverage cannot be bound without signature or if this application is incomplete.

**THE UNDERSIGNED REPRESENTS TO THE BEST OF HIS OR HER BELIEF AND KNOWLEDGE, AFTER REASONABLE INQUIRY AND DUE DILIGENCE, THE STATEMENTS SET FORTH IN THIS APPLICATION AND ANY SUPPLEMENTS THERETO ARE TRUE AND CORRECT.**

**THE UNDERSIGNED DECLARES THAT ANY CLAIM, INCIDENT OR CIRCUMSTANCE TAKING PLACE PRIOR TO THE EFFECTIVE DATE OF THE INSURANCE APPLIED FOR WILL IMMEDIATELY BE REPORTED IN WRITING TO THE INSURER. AS A RESULT, THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.**

**THE SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERSIGNED TO PURCHASE THE INSURANCE, NOR DOES THE REVIEW OF THIS APPLICATION BIND THE INSURANCE COMPANY TO ISSUE A POLICY.**

**THE APPLICANT UNDERSTANDS AND AGREES THIS APPLICATION AND ANY SUPPLEMENTS THERETO SHALL BE INCORPORATED INTO ANY POLICY THAT MAY ISSUED AND THE UNDERWRITERS ARE RELYING ON THE TRUTH OF THE STATEMENTS SET FORTH HEREIN IN MAKING A DETERMINATION TO ISSUE ANY POLICY. THE APPLICANT ALSO UNDERSTANDS AND AGREES THIS APPLICATION FOR COVERAGE DOES NOT MEAN ANY REQUESTED COVERAGES, LIMITS OR DEDUCTIBLES SHALL BE GRANTED IN FACT; UNDERWRITERS MUST AGREE TO ANY REQUESTS WHETHER IN THE APPLICATION TO OTHERWISE.**

**THE UNDERSIGNED INDIVIDUAL REPRESENTS HE OR SHE IS DULY AUTHORIZED AND EMPOWERED TO MAKE THIS APPLICATION, INCLUDING THE REPRESENTATION, ON BEHALF OF THE APPLICANT OR ANY INDIVIDUAL WHO MAY SEEK COVERAGE UNDER ANY BINDER OR INSURANCE POLICY ISSUES IN RELIANCE HEREON.**

**FRAUD WARNING: 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.**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Applicant Signing Above

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