

SUPPLEMENTARY CLAIMS INFORMATION

Please use separate form for each claim, if there has been more than one claim.

IMPORTANT: The word claim as used in question #10 refers to:

1. Any suit or claim, settled or pending, regardless of the result, arising from your professional activity and brought against you or any partner, associate or employee, or
2. Circumstances which have been brought to your attention by a patient or representative of a patient, in such a manner as to indicate the possibility of legal action against you.

Complete information is necessary to avoid possible complications under your insurance policy issued in reliance upon this application.

PATIENT S NAME _____

ADDRESS _____

DATE OF INCIDENT AND YOUR TREATMENT _____

ALLEGATIONS _____

PRESENT STATUS OF CLAIM: (check applicable answer)

- | | |
|--|---|
| <input type="checkbox"/> 1. Suit threatened, no action taken | <input type="checkbox"/> 5. Court trial in your favor |
| <input type="checkbox"/> 2. Dropped by claimant | <input type="checkbox"/> 6. Out of court settlement in the amount of \$ _____ |
| <input type="checkbox"/> 3. Awaiting court action | <input type="checkbox"/> 7. Court settlement in the amount of \$ _____ |
| <input type="checkbox"/> 4. Summary judgment in your favor | <input type="checkbox"/> 8. Waiting for mediation |

AT THE TIME OF CLAIM, YOUR INSURANCE COMPANY WAS _____

POLICY NUMBER _____

ATTORNEY WHO REPRESENTED YOU AND HIS ADDRESS _____

THE ABOVE IS A TRUE AND CORRECT STATEMENT AND BY SIGNING THIS FORM, I HEREBY AUTHORIZE MY PRIOR INSURANCE COMPANY TO RELEASE ANY CLAIM INFORMATION REQUESTED BY THE FPIC.

Date _____ Signature _____

(A photostatic copy of this authorization shall be considered as effective and valid as the original.)

If any of the following questions are answered **YES** give full details on a separate sheet of paper and attach to application. **ALL QUESTIONS MUST BE ANSWERED.**

1. Have you ever been convicted of a felony? _____ A misdemeanor? _____
2. Are you now or have you ever been addicted to the use of narcotics? _____
Have you ever been charged with addiction? _____
3. Have you ever been addicted to the use of barbiturates or any other medication? _____
Have you ever been charged with addiction? _____
4. Have you ever engaged in excessive use of alcohol or received treatment for alcoholism? _____
5. Have you ever been adjudged mentally incompetent or been voluntarily committed to a mental institution? _____

Date _____ Age _____ Height _____ Weight _____

Color of Eyes _____ Color of Hair _____

Other means of identification _____

The foregoing answers and statements are complete and correct to the best of my knowledge and belief.

Signature of Physician s Assistant

FPIC
P. O. Box 44033
Jacksonville, Florida 32231-4033

TO BE COMPLETED BY PHYSICIAN

APPLICATION FOR DESIGNATED EMPLOYEE COVERAGE: Physician s Assistant

(All statements below must be completed and all questions answered completely.)

PHYSICIAN INFORMATION

1. Name _____ Phone No. (____) _____
2. Office Address(es) _____

3. Type of Practice _____
4. Board Certification _____
5. Florida Medical License Number _____ Date Issued _____

PHYSICIAN S ASSISTANT INFORMATION

6. Name _____ Age _____
7. Present Address _____
8. Graduated from _____
Date Graduated _____
9. Other Medical Training or Experience (give dates) _____

PRACTICAL UTILIZATION

Name(s) and address(es) of any other physician(s) who will serve as responsible physician for the above named Physician s Assistant:

10. Name _____ Phone No. (____) _____
11. Office Address(es) _____

12. Type of Practice _____
13. Board Certification _____
14. Florida Medical License Number _____ Date Issued _____

15. Describe role, activities and functions to be performed by the Physician s Assistant in your office.

16. Describe role, activities and functions to be performed by the Physician s Assistant in the hospital setting.

17. Describe role, activities and functions to be performed by the Physician s Assistant in other practice setting.

18. Describe in detail the acts, tasks and functions that the Physician s Assistant will be allowed to perform under your indirect supervision (i.e. away from your presence), and the safeguards (standing orders, backup arrangements, access via telephone, etc.) which you have established for the protection of the patient.

19. The foregoing answers and statements are complete and correct to the best of my knowledge and belief.

Date Signature of Physician