



*** Application for House Staff: Interns/Residents/Fellows**

CORPORATE MEDICAL INSURANCE COMPANY OF VERMONT, INC. (INSURANCE GROUP)
CORPORATE MEDICAL INSURANCE COMPANY, LTD.

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Physician Application

Please type or print responses in ink, and answer all questions in full. If a question does not apply to you, state "none" or "NA" (Not Applicable). If you require more room for your answers, please attach additional pages.

If you have any questions, please contact the Underwriting Department at Risk Management Foundation, 617-495-5100, *your department or Ruthie Pistorino (617-667-1913).*

Mail original form to:
Risk Management Foundation of the Harvard Medical Institutions
101 Main Street, Cambridge, MA 02142

New Applicant Status Change Specialty Change Other

General Information **1** Name

Last _____ Degree _____
First _____ Middle _____ Suffix _____
Position Title, e.g. "Chief of Service," "Director," "Chief Medical Resident," etc. _____

2 Age & Sex

Date of Birth: Male Female

3 Social Security #

- -

4 Training End Date
Residents & Fellows only

When does your program terminate? _____ (MM/DD/YY)

Institution Affiliation **5** Sponsoring Institution

BIDMC Medicine Dr. Mark Zeidel
Institution sponsoring your malpractice insurance Department Chief of Service

6 Primary Employer

Sponsoring Institution Other: _____
e.g. Foundations, Professional Corporations, Physician Practice Groups, etc.

Coverage History **7** Previous Insurers
Attach additional pages if necessary.

N/A for Residents, Fellows

Insurer	Policy #	Location where you practiced (facility & state)	Any claims?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Start date (MM/DD/YY)	End date (MM/DD/YY)				
Insurer	Policy #	Location where you practiced (facility & state)	Any claims?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Start date (MM/DD/YY)	End date (MM/DD/YY)				
Insurer	Policy #	Location where you practiced (facility & state)	Any claims?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Start date (MM/DD/YY)	End date (MM/DD/YY)				

8 Ten-year Claims History

N/A
Attach all insurance company(ies) report(s) of claims history for your last ten years in practice. The ten-year claims history should include your policy number(s), coverage dates, and for each claim the claim number, description of loss, final disposition, and settlement amount. You must submit the report(s) whether or not you have ever been named in a claim or suit.

Questions continue on page two.



Physician Application

Addresses

Please provide the address of each site at which you practice. Attach additional pages if necessary.

9 Business Address
(while working for BIDMC)

Department: Medicine Division: Internal Medicine
 Building/Suite/Number: DEAC311 Street: 185 Pilgrim Road
 City: Boston State: MA Zip: 02215

Other Site
If applicable

Department: _____ Division: _____
 Building/Suite/Number: _____ Street: _____
 City: _____ State: _____ Zip: _____

10 Home Address
Optional

Street: _____ Apartment/unit number: _____
 City: _____ State: _____ Zip: _____

11 Contact Information
(while working for BIDMC)

Business Phone: (617) 667-7000 Business Fax: _____
 Business E-mail: _____ @ _____ Beeper/cell number: _____
 Home Phone: _____ Home Fax: _____
 Home E-mail: _____ @ _____

12 Primary Contact

Where would you like to receive correspondence from CRICO? (check one)
 Business Home - if you select home please answer #10.

Credentialing

Attach additional pages if necessary.

13 Medical Education

Medical School: _____
 City: _____ State/Country: _____ Graduation Date: _____ (year)
 Medical School: _____
 City: _____ State/Country: _____ Graduation Date: _____ (year)

14 License(s)

MA State License Number: _____ Renewal Date: _____ (MM/DD/YY)
 State License Number: _____ Renewal Date: _____ (MM/DD/YY)

15 Coverage
To be completed by the sponsoring institution.

Effective date of coverage: 06/23/2010
 MM/DD/YY

16 Status

Staff Physician Fellow Resident

17 Employment Status

Employee (minimum salary \$15,000) Volunteer-HSDM Retiree
 New Member - Must be pre-approved by CRICO
 Other (e.g. non-employed physician): Complete CRICO Eligibility Supplementary Form

Questions continue on page three.



Physician Application

Specialty Class **18** Specialty
Estimate the percentage of professional time devoted to each (if zero, leave blank).

a) Specialties with No Surgery

% Cardiology	% Geriatrics	% Neurology (inc. child)	% Pulmonary Disease
% Dermatology	% Hematology	% Nuclear Medicine	% Radiology (diagnostic)
% Diabetes	% Immunology	% Oncology	% Rheumatology
% Endocrinology	% Infectious Disease	% Ophthalmology	% Other: _____
% Family Practice	% Intensive Care Med.	% Pathology	
% Gastroenterology	% Internal Medicine	% Pediatrics	% Other: _____
% Genetics	% Nephrology	% Podiatry	

b) Specialties with Minor Surgery

Cardiology:	% Family Practice	% Internal Medicine	Radiology:
% with catheter	% Gastroenterology	% Nephrology	% with arteriography
% without catheter	% Geriatrics	% Neurology	% with invasive procedures
% Dermatology	% Gynecology	% Pathology	% Other: _____
% Diabetes	% Hematology	% Pediatrics	
% Endocrinology	% Infectious Disease	% Pulmonary Disease	

c) Specialties with Major Surgery

% Anesthesiology	% Head & Neck	% Ophthalmology	% Thoracic
% Cardiac	% Neurosurgery	Otorhinolaryngology:	% Urological
% General	% Obstetrics	% with plastic	% Vascular
% Gynecology	% Oncology	% without plastic	% Other: _____
% Emergency Medicine	% Oral Surgery	% Plastic	
% Hand	% Orthopedic	% Podiatric	% : _____

d) Other Specialties

% Allergy	% Intensive Care Med.	Psychiatry:	% Psychiatric Medicine
% Dentistry	% Neonatology	% with ECT	% Other: _____
% Emergency Medicine	% Occupational Med.	% without ECT	

e) Are you a Hospitalist? Yes No

19 Procedures
Some specific procedures influence underwriting class assignment.

Please estimate the number you perform per month.

# Acupuncture	# Bronchoscopy	# Colonoscopy	# Pacemaker placement (temporary)
# Amniocentesis	# Cardiac catheterization	# Endoscopy	# Pacemaker placement (permanent)
# Angiography	# Catheter placement (central artery, Swan-Ganz, umbilical)	# Hysteroscopy	# Vaginal deliveries
# Arteriography		# Laparoscopy	# C-sections
# Arthroscopy		# Laser Therapy	
# Biopsy (nerves, muscles, significant internal organs)	# Circumcision	# Liposuction	
		# Other: _____	



Physician Application

Professional Functions *(continued)*

20 Board Certification(s)

Name of Board: _____

Name of Board: _____

Name of Board: _____

Professional Functions

21 Professional Activities & Volume
Indicate your average level of activity.

	Direct Patient Care	Supervised (Precepting) Patient Care	Administration	Research	Teaching
Hours per week	# 8.0	# 8.0	#	#	#
Patients per hour in an office setting	# 1-3	# 1-3			

_____ office sessions per week

_____ total number of patients for whom you are responsible (panel size)

22 Privileges
Please name any organizations of which you are a member.

N/A For Residents/Fellows

Hospital _____

Date (MM/DD/YY) _____

Direct care Indirect care

Hospital _____

Date (MM/DD/YY) _____

Direct care Indirect care

Professional Corporation or Physician Practice Group (Do not include medical associations or societies.)

Independent Practice Association

Physician Hospital Organization

23 Teaching Status
Harvard Academic Appointment only.

- Full Professor
- Associate Professor
- Assistant Professor

Instructor/Lecturer

Not applicable

Other: Clinical Fellow in Medicine

Student Type
Check all that apply.

- Attending physicians
- Dental students
- Medical students

Nurses

Residents/fellows

Other: _____

Legal Background

24 Hospital Discipline
Including restriction of privileges

Name of Hospital _____

City and State or City and Country _____

Date of Action _____

Result of Action _____

I have had no hospital disciplinary actions or restrictions of privileges in the past ten years.

25 State Board Disciplines
Or other governmental body

Board Name _____

City and State or City and Country _____

Date of Action _____

Result of Action _____

I have had no state board disciplinary actions in the past ten years.

26 Criminal Convictions

Crime of which you were convicted _____

City and State or City and Country where charged _____

Date of Conviction _____

Sentence _____

I have not been convicted of any crimes by any governmental agency in the past ten years.

27 Criminal Indictments

Accusation _____

City and State or City and Country where indicted _____

Date of Indictment _____

Result of Indictment _____

I have not been under indictment for any criminal or civil offense in the past ten years.

Questions continue on page five.



Physician Application

Signatures

28 Release of Information
Note: Your signature is required following this Release of Information statement.

I hereby authorize Controlled Risk Insurance Company of Vermont, Inc. and Controlled Risk Insurance Company, Ltd. (CRICO) and Risk Management Foundation (RMF) to obtain full information from any insurance company or from any person with respect to me or my medical practice, including, but not limited to, any claim or suit or incident pertaining to professional acts or omissions asserted against me and/or my partnership or professional corporation. I understand all information so furnished to CRICO and RMF, whether orally, in writing, or electronically, shall be held in confidence and used solely for the purpose of providing professional liability insurance, including underwriting risk and reporting as required by law. I expressly release and discharge from liability any insurance company or persons providing such information. I further authorize that a photocopy of this release be accepted with the same authority as the original.

A

Personal Signature of Applicant

Date Signed

29 Physician's Attestation *A*

The information I have provided is complete and accurate.

Personal Signature of Applicant

Date Signed

30 Authorization
To be completed by the sponsoring institution.

It is the responsibility of the sponsoring institution to review and meet CRICO eligibility requirements prior to adding any new physicians.

JCAHO requirement met? Yes No
 State requirement met? Yes No

Anne Marie Jarvey
 Name of authorized institution representative (print)

Director OPSA + RC
 Title

Authorized signature

Date Signed

A written notice of coverage acceptance or coverage denial will be issued within 30 days of receipt of this application.



Physician Application: CRICO Eligibility Supplement

If you selected "other" on question 17 of the *CRICO Physician Application*, you must complete this supplementary form to determine your eligibility for the CRICO insurance program.

Hospital Affiliation
Attach additional pages if necessary.

S1 Admitting Privileges

List all institutions to which you admit patients, and the percent of your patients admitted to each.

_____ Institution _____	% admitted
_____ Institution _____	% admitted
_____ Institution _____	% admitted
_____ Institution _____	% admitted

S2 Founding Member Work

What percent of your clinical practice and professional effort do you conduct at one or more of the CRICO member institutions* or subsidiaries?

≤ 50% > 50 and ≤ 75% > 75%

Physician Practice Group Affiliation
Complete this section if you are a member of a Physician Practice Group.

S3 Group Ownership

Does your sponsoring institution have ownership equity in your group? yes no

If "yes," what percent does the sponsor own? _____

S4 HPHC Enrollment

What percent of your patients are enrolled through Harvard Pilgrim Health Care? _____

S5 Contractual Relationship

Do you have a contractual relationship for patient care services with your sponsoring institution? yes no

Signature

S6 Physician Signature

The information I have provided is complete and accurate.

Signature

Date

Print Name

- *CRICO Member Institutions
- | | |
|--|---------------------------------------|
| The Children's Medical Center | Insulin Diabetes Center, Inc. |
| Cambridge Health Alliance | Judge Baker Children's Center, Inc. |
| CareGroup, Inc. | Massachusetts Eye and Ear Infirmary |
| Beth Israel Deaconess Medical Center, Inc. | Massachusetts Institute of Technology |
| BIDMC—Newman Campus | Partners HealthCare System, Inc. |
| Mount Auburn Hospital | Brigham and Women's Hospital |
| New England Baptist Hospital | Faulkner Hospital |
| Dana-Farber Cancer Institute, Inc. | The Massachusetts General Hospital |
| Harvard Vanguard Medical Associates, Inc. | McLean Hospital |
| Harvard Pilgrim Health Care, Inc. | North Shore Medical Center |
| Presidents and Fellows of Harvard College | Newton-Wellesley Hospital |
| Harvard Medical School | Spaulding Rehabilitation Hospital |
| Harvard School of Dental Medicine | |
| Harvard School of Public Health | |
| Harvard University Health Services | |