University of Florida J. Hillis Miller Health Center Self-Insurance Program

PHYSICIANS PROFESSIONAL LIABILITY QUESTIONNAIRE
for
Clinical Physician Employees of Shands Healthcare

Name: _____

SS#: _____ FL Medical License #: _____

Date of This Questionnaire: _____ Date of Hire or Anticipated Hire: _____

Employer: _____

Department: _____

Division: _____

Employment FTE: _____ Clinical FTE: _____

Specialty: _____ Subspecialty(ies): _____

_____

Briefly describe your practice or intended practice under this employment.

_____

_____

_____

Employment -Related Patient Care Practice Locations (hospitals, clinics, etc.):

☐ Shands at UF ☐ Shands Vista

☐ Shands at Rehab Hospital ☐ Shands Medical Group of Magnolia Parke

☐ Other Identify: _____

_____

Will you be engaged in any clinical services **outside** the scope of your employment?

◯ Yes ◯ No

If yes, please describe: _____

_____

Please identify your medical malpractice insurer for those activities

_____

_____

Attach a copy of your C.V., to include:
Education, Additional Training, Practice History, and Board Certifications

PHYSICIAN UNDERWRITING INFORMATION

Name: _____

Check the "Yes" or "No" block for each of the following:

a. Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended, placed on probation, subjected to reprimand, voluntarily surrendered or in any other way limited, or has it been or is it currently under investigation? If "Yes," explain. ◯ Yes ◯ No

b. Have you ever been or are you currently under a Consent Order? If "Yes", attach a copy of the Consent Order and its termination, if applicable. ◯ Yes ◯ No

c. Have your hospital staff privileges ever been denied, suspended, revoked, placed on probation, voluntarily surrendered or in any other way restricted, or have they been or are they currently under investigation? If "Yes," explain. ◯ Yes ◯ No

d. Has any insurance company ever canceled, declined to issue or refused to renew your professional liability insurance, or offered such insurance only on special terms, or have you been notified of such intent? (Enclose copy of Cancellation Notice or Letter if applicable.) ◯ Yes ◯ No

e. Have you ever been contacted by an attorney either requesting records of a case in which there are unexpected injuries or notifying you that a malpractice action is being investigated or contemplated against you? If "Yes", complete the Claim Supplement for each incident. ◯ Yes ◯ No

f. Has any civil action ever been filed against you alleging medical errors or omissions, or against your employer or any other entity responsible for or alleged to be responsible for your patient care activities, or have you been notified that such an action will be filed? If "Yes", complete the Claim Supplement for each claim. ◯ Yes ◯ No

g. Have any judgments been made against you, or any out-of-court settlements been made on your behalf, from an incident alleging medical errors or omissions? If "Yes", complete the Claim Supplement for each claim. ◯ Yes ◯ No

h. Have you ever been convicted of a criminal offense or are you under investigation for a criminal offense? If "Yes," explain. ◯ Yes ◯ No

i. Have you been treated for alcoholism or drug addiction within the last five years? (If "Yes," provide dates and locations of all treatments, and the names of your supervising and monitoring physicians.) ◯ Yes ◯ No

j. Have you received any major medical/surgical treatment for illness or accident during the past five years? ◯ Yes ◯ No

k. Do you enter into any oral or written contract or agreement guaranteeing the result of any treatment or operation performed by you, personally, or performed under your supervision? If "Yes," explain. ◯ Yes ◯ No

l. Do you practice any unconventional or experimental therapies? If "Yes," describe. ◯ Yes ◯ No

m. Do you engage in telemedicine? If "Yes," describe. ◯ Yes ◯ No

n. Do you serve as Medical Director or Assistant Medical Director for any facility or clinical department that will **not** be pursuant to this employment? If "Yes," describe. ◯ Yes ◯ No

o. Do you serve as Medical Director or Assistant Medical Director for any facility or clinical department pursuant to this employment? If "Yes," describe. ◯ Yes ◯ No

p. As part of this employment, do you supervise any physician/surgeon assistants, ARNP's or CRNA's? If "Yes," provide details: ◯ Yes ◯ No

q. Do you supervise any physician/surgeon assistants, ARNP's or CRNA's **outside** the scope of this employment? If "Yes," provide details: ◯ Yes ◯ No

"Yes" answers to "e", "f" and "g" require the completion of the Claim Supplement for each incident and/or claim. Attach a separate sheet to explain/describe other "Yes" answers.

LIABILITY RATING INFORMATION

Name: _____

Limit your responses to patient care that you are, or anticipate will be, providing on behalf of the employer, Shands Healthcare. Including patient care in the rating information below that you are or may be qualified to provide but that is not anticipated to be provided within the scope and course of your employment could result in an unnecessarily higher premium than would otherwise be assessed.

Surgery Class:

◯ **NONE** **Includes** incision of boils & superficial fascia, suturing of minor lacerations and removal of superficial skin lesions by other than surgical excision. **Excludes** performing and/or assisting with surgery or OB procedures.

◯ **MINOR** Includes simple operations not considered to involve a risk to life, circumcisions, & non-major OB procedures. Excludes all surgeries and procedures that meet the criteria of major surgery.

◯ **MAJOR** Includes removal of tumors, open bone fractures, amputations, removal of any gland or organ, plastic surgery, tonsillectomy, adenoidectomy, caesarean section, and any operation in or upon any body cavity including but not limited to cranium, thorax, abdomen or pelvis or any other operation which because of the condition of the patient or the length or circumstances of the operation presents a distinct hazard to life.

Medical or Surgical Speciality:

- ☐ Anesthesiology
- ☐ Emergency Medicine
- ☐ Family Practice/ Gen
- ☐ Internal Medicine
- ☐ Neurological Surgery
- ☐ Neurology
- ☐ OB & Gynecology
- ☐ Ophthalmology
- ☐ Orthopaedics
- ☐ Otolaryngology
- ☐ Pathology
- ☐ Pediatrics
- ☐ Podiatry
- ☐ Psychiatry
- ☐ Radiation Therapy
- ☐ Radiology
- ☐ Surgery
- ☐ Other (define): _____

Medical or Surgical Sub-Speciality

- ☐ Abdominal
- ☐ Aerospace Medicine
- ☐ Allergy
- ☐ Broncho-Esophagology
- ☐ Cardiac
- ☐ Cardiovascular Disease
- ☐ Colon & Rectal
- ☐ Dermatology
- ☐ Diabetes
- ☐ Endocrinology
- ☐ Family Practice
- ☐ Forensic Medicine
- ☐ Gastroenterology
- ☐ General
- ☐ Geriatrics
- ☐ Gynecology
- ☐ Hand
- ☐ Head & Neck
- ☐ Hematology
- ☐ Infectious Disease
- ☐ Intensive Care
- ☐ Laryngology
- ☐ Neonatology
- ☐ Neoplastic Disease
- ☐ Nephrology
- ☐ Nuclear Medicine
- ☐ Neurology
- ☐ Nutrition
- ☐ Obstetrics
- ☐ Occupational Med.
- ☐ Ophthalmology
- ☐ Oral Surgery
- ☐ Orthopaedics
- ☐ Otology
- ☐ Otorhinolaryngology
- ☐ Otorhinolaryn/Plastic
- ☐ Pain Management
- ☐ Pathology
- ☐ Pediatrics
- ☐ Pharmacology, Clin.
- ☐ Physiatry
- ☐ Physical Med/Rehab
- ☐ Plastic
- ☐ Podiatry
- ☐ Preventative Med.
- ☐ Psychiatry
- ☐ Psychoanalysis
- ☐ Psychosomatic Med
- ☐ Pulmonary
- ☐ Radiology
- ☐ Rheumatology
- ☐ Rhinology
- ☐ Schlerotherapy
- ☐ Thoracic
- ☐ Traumatic
- ☐ Urology
- ☐ Vascular
- ☐ Other (define): _____

Medical Techniques or Procedures

- ☐ Acupuncture (other than acupuncture anesthesia)
- ☐ Angiography
- ☐ Arteriography
- ☐ Catheterization/Arterial, cardiac or diagnostic (see exclusion 1 below)
- ☐ Colonoscopy
- ☐ Discogram
- ☐ Endoscopic Retrograde Cholangiopancreatography
- ☐ Electroconvulsive Therapy
- ☐ Laparoscopy
- ☐ Lasers
- ☐ Lymphangiography
- ☐ Myleography
- ☐ Needle Biopsy (see exclusion 2 below)
- ☐ Phlebography
- ☐ Pneumatic or Mechanical Esophageal Dilation (see exclusion 3 below)
- ☐ Pneumoencephalography
- ☐ Radiation Therapy
- ☐ Radiopaque Dye Injections into blood vessels, lymphatics, sinus tracts or fistulae (see excl 4 below)

Exclusion 1: Does not include occasional emergency insertion of pulmonary wedge pressure recording or temporary pacemaker, urethral caths, or umbilical cord cath for diagnostic purpose or for monitoring blood gases in newborns on oxygen
Exclusion 2: Does not include fine needle aspiration, and does not include liver, kidney or bone marrow biopsy
Exclusion 3: Does not include dilation with bougie or olive
Exclusion 4: Not applicable to Radiologists

INCIDENT REPORTING REQUIREMENTS
of
UNIVERSITY OF FLORIDA J. HILLIS MILLER HEALTH CENTER SELF INSURANCE PROGRAM

Non-Delegable Responsibility:
Each individual who is an employee or agent of a protected entity of the Program has a non-delegable responsibility to report to the Program any occurrence or circumstance which has the potential of becoming a liability claim against you and/or your employer and/or the facility at which the circumstance occurred.

Incidents or Circumstances Required to be Reported:
Recognizing that no definition of a reportable incident will cover all circumstances and that it is often the magnitude of an injury rather than the actual quality of the care delivered that causes malpractice claims to be filed, the following conditions or incidents are among those which must be reported if they manifest while the patient is undergoing therapy or surgery:

1. Surgical procedure on the wrong patient
2. Attempted wrong site surgery, to include prepping the wrong site
3. Wrong site or wrong procedure surgery
4. Any condition that requires transfer to a higher level of care within or outside the facility
5. Retained foreign body
6. Surgical repair of injuries or damage from planned surgical procedure where damage is not a recognized specific risk disclosed to the patient and documented through informed consent process
7. Total or partial loss of limb, or loss of the use of a limb
8. Sensory organ or reproductive organ impairment
9. Disability or disfigurement
10. Any birth of a term baby that is stillborn or expires shortly after delivery
11. Injury or death to either mother or child during delivery
12. Shoulder dystocia resulting in a fracture or other injury
13. Delay or misdiagnosis of a patient's condition resulting in increased morbidity
14. Medication errors leading to injury, death, or higher level of care
15. Injury to any part of the anatomy not undergoing treatment
16. Any assertion by a patient of medical injury or a threat of litigation
17. Allegations of rape or sexual abuse or misconduct
18. Patient or family assertion that no consent was obtained for treatment (medical or surgical)
19. Any condition requiring specialized medical attention resulting from non-emergency medical intervention to which the patient has not given informed consent
20. Infant abduction or discharge of an infant to the wrong parents
21. Any incident that results in an unexpected death, brain or spinal damage, or any other injury not referenced above
22. Any other unexpected or adverse outcome or an event where established policy or procedure was not followed
23. Any other conditions that you feel may result in a claim

Standard reporting guideline:

The best guideline to follow for determination of whether a circumstance is reportable is that of common sense, sustained by the ever present awareness of the possibility of a claim. The standard practice should be: **when in doubt, report**.

UNIVERSITY OF FLORIDA J. HILLIS MILLER HEALTH CENTER SELF INSURANCE PROGRAM

PHYSICIANS PROFESSIONAL LIABILITY QUESTIONNAIRE

COVERAGE RESTRICTION & INFORMATION:

Medical malpractice liability protection provided by the above named Program is restricted to incidents and claims arising out of patient care rendered within the scope and course of your employment with Shands Healthcare.

Coverage **may** be extended to community services approved by the employer and extends to Good Samaritan acts.

Specific coverage questions can be directed to:
UFHSC Self-Insurance Program Insurance Services
Telephone: 352-273-7006

PHYSICIAN REPRESENTATIONS:

I hereby declare that the statements and responses I have provided in this questionnaire are, to the best of my knowledge and recollection, complete and correct and that I have not deliberately suppressed or misstated any material facts.

Further, I have read and agree to abide by the Incident Reporting Requirements.

_____
(signature)

Print Name: _____

Date: _____

Telephone Contact Numbers:

_____

_____

E-Mail: _____

Mailing Address:

_____

_____

_____

_____

EMPLOYER REPRESENTATIONS: Hospital Administrator

I hereby declare that the statements and responses the physician has provided in this questionnaire identifying the practice locations,patient care categories, and FTE's for his/her employment activities are correct. I further represent that if any material change occurs during the term covered by this application, I will notify the Insurance Services division of the Self Insurance Program.

_____
Hospital Administrator (signature)

Print Name: _____

Title: _____

Date: _____

Please email completed form to: ufisosip@mail.ufl.edu

UNDERWRITING FORM - CLAIM SUPPLEMENT

Name: _____

Patient (or Plaintiff) _____ Date of Incident: _____

_____

If no lawsuit, how did you become aware of this as a potential or actual malpractice claim?

_____

_____

Where did the incident occur (facility, city and state)?

_____

_____

Give a summary of the allegations or potential allegations:

_____

_____

_____

Give a summary of the alleged or potentially alleged injuries/damages:

_____

_____

_____

Give a summary of your involvement in the patient's treatment:

_____

_____

_____

If the claim has been resolved, provide details, dates, and amounts:

_____

_____

If the claim has not been resolved, provide current status:

_____

_____

Defense Attorney (name/address):

_____

_____

_____

_____

Insurer (name/address):

_____

_____

_____

_____

Attach an additional sheet if you need more space or wish to provide additional information.

AUTHORIZATION FOR RELEASE OF INFORMATION

The undersigned hereby authorizes the release of information as specified below to:

The University of Florida J. Hillis Miller Health Center Self Insurance Program, hereafter referred to as "Program."

The undersigned hereby authorizes his/her present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the below named, upon its request, information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney or the Program may have a bearing upon his/her professional liability risk factors.

The undersigned also authorizes all medical associations, medical societies and managed care organizations in which he/she is or has been a member, all hospitals in which he/she now holds or has held staff privileges, the state board of medical examiners for the state in which he/she has practiced, the state department of public health for the state in which he/she has practiced or resided, motor vehicle departments, and any and all physicians having information regarding the undersigned, to release to the Program upon its request any information any such person or entity may have which, in the judgment of any such person or entity, has a bearing upon his/her professional liability risk factors.

_____

(name, typed or printed)

_____

(signature)

Date: _____

UNDERWRITING FORM - INSURANCE HISTORY

Name: _____

List all previous and/or current medical malpractice insurance carriers.

Carrier: _____

Policy Number: _____ Policy Period: _____

Coverage Type: ☐ Claims-made ☐ Occurrence

Carrier: _____

Policy Number: _____ Policy Period: _____

Coverage Type: ☐ Claims-made ☐ Occurrence

Carrier: _____

Policy Number: _____ Policy Period: _____

Coverage Type: ☐ Claims-made ☐ Occurrence

Carrier: _____

Policy Number: _____ Policy Period: _____

Coverage Type: ☐ Claims-made ☐ Occurrence

Carrier: _____

Policy Number: _____ Policy Period: _____

Coverage Type: ☐ Claims-made ☐ Occurrence