Florida State University College of Medicine Self-Insurance Program
www.myflsip.org

PROFESSIONAL LIABILITY QUESTIONNAIRE

Florida State University Board of Trustees Employee/Agent (BOT): Please type or print responses and answer all questions in full. If a question does not apply to you, state "none" or "N/A" (not applicable). If you require additional space for your answers, please attach additional pages.

Date of Hire or Anticipated Hire: _____ Reset Form

GENERAL INFORMATION

Provider Name: _____ Degree: _____
(Last, First, Middle)

BOT ID#: _____

Other Legal Name(s): _____

FL Board License # (Please include prefix, e.g., ME, OS, PA, APRN): _____

Contact Information:

Cell Phone: _____

Work Phone: _____ Work e-Mail: _____

Home Phone: _____ Personal e-Mail: _____

BOT INSTITUTION AFFILIATION

Employer/College: _____ Department: _____

Division: _____ Employment FTE %: _____ Clinical FTE %: _____

Position Title: _____

List all BOT related patient care practice locations (facility name, city, state):

_____

_____

_____

COVERAGE RESTRICTION & INFORMATION

Healthcare professional liability protection provided by the above-named self-insurance program (SIP) is restricted to incidents and claims arising out of patient care rendered within the scope and course of your employment/appointment with the BOT.

For questions related to medical malpractice liability protection, please call 352-273-7006, or 844-MY FL SIP, or visit our website at: MY FL SIP.org, or specifically https://flbog.sip.ufl.edu/liability-protection-afforded.

PRIVATE PHYSICIANS: When educating, training, and supervising the clinical services performed by BOT fellows, residents, and/or students, private physicians have a limited personal immunity as set forth in Section 768.28(9), Florida Statutes. The limited personal immunity of Section 768.28(9), Florida Statutes, protects private physicians from claims of vicarious liability (respondeat superior) arising from alleged negligent acts or omissions of the BOT fellows, residents, and students. The exclusive remedy for alleged negligent acts or omissions of BOT fellows, residents, and students is an action against the BOT. NOTE: Patient care personally provided by private physicians does NOT trigger the limited immunity of Section 768.28(9), Florida Statutes. A private physician is solely responsible for patient care provided and must individually satisfy Florida's professional liability financial responsibility requirements applicable to physicians.

UNDERWRITING INFORMATION

Provider Name: _____

1. Will your BOT employment/appointment require travel outside the state of Florida to provide clinical services? ○ Yes ○ No

If YES,

Estimated annual hours dedicated to this service: _____

List states serviced: _____

List the facility name and city of the out of state service location(s): _____

_____

Describe clinical services that will be provided: _____

2. Will your BOT employment/appointment include Telemedicine? (Telemedicine Definition: The practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment). ○ Yes ○ No

If YES,

List states serviced: _____

List the facility name and city of the location(s) from which you will be providing the telemedicine services:

_____

Describe the telemedicine services that will be provided: _____

3. 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", please attach a detailed written explanation. ○ Yes ○ No

4. 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

5. 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," please attach a detailed written explanation. ○ Yes ○ No

6. 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? If "Yes," please attach a copy of the Cancellation Notice or Letter, if applicable. ○ Yes ○ No

7. Have any claims been asserted or civil actions filed against you alleging 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," please complete a Claim Supplement (form attached) for each claim and civil action. ○ Yes ○ No

8. Have any judgments been made against you, or any out-of-court settlements been made on your behalf, from an event alleging medical errors or omissions that was not addressed in "7." above? If "Yes," please complete a Claim Supplement (form attached) for each claim. ○ Yes ○ No

9. Have you ever been convicted of a criminal offense or are you under investigation for a criminal offense? If "Yes," please attach a detailed written explanation. ○ Yes ○ No

10. Have you been treated for alcoholism or drug addiction within the last five years? If "Yes", please attached a detailed written explanation including dates and locations of all treatments and the names of your supervising and monitoring physicians. ○ Yes ○ No

11. Have you incurred or become aware of having a condition that impairs your ability to practice your specialty? If "Yes," please attach a detailed written explanation. ○ Yes ○ No

RATING INFORMATION

Provider Name: _____

Limit your below responses to patient care that you are, or anticipate will be, providing on behalf of the BOT. Please do not include information on patient care that you are or may be qualified to provide but do not anticipate you will be providing on behalf of your employer. Doing so could result in an unnecessary increase in SIP funding.

Surgery Class:

- ◯ **NONE** — **Includes** incision of boils & superficial fascia, suturing of minor lacerations and removal of superficial skin lesions by other than surgical excision.
- ◯ **MINOR** — **Includes** 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 that 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 Med/Gen Med
- ☐ 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
- ☐ Bariatric
- ☐ Broncho-Esophagology
- ☐ Cardiac
- ☐ Cardiovascular Disease
- ☐ Critical Care
- ☐ Colon & Rectal
- ☐ Dermatology
- ☐ Diabetes
- ☐ Endocrinology
- ☐ Family Medicine: *Includes Deliveries (Requires NICA Cert)*
- ☐ Family Medicine: *Excludes Deliveries*
- ☐ Forensic Medicine
- ☐ Gastroenterology
- ☐ General
- ☐ Genetics
- ☐ Geriatrics
- ☐ Gynecology
- ☐ Hand
- ☐ Head & Neck
- ☐ Hematology
- ☐ Hospice/Palliative Care
- ☐ Hospitalist
- ☐ Infectious Disease
- ☐ Intensive Care
- ☐ Laryngology
- ☐ Neonatology
- ☐ Nephrology
- ☐ Nuclear Medicine
- ☐ Neurology
- ☐ Nutrition
- ☐ Obstetrics *Includes Deliveries (Requires NICA Cert)*
- ☐ Obstetrics *Excludes Deliveries*
- ☐ Occupational Med
- ☐ Oncology/Neoplastic Diseases
- ☐ Ophthalmology
- ☐ Oral Surgery
- ☐ Ortho:Excluding Spine
- ☐ Ortho: Including Spine
- ☐ 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
- ☐ Sclerotherapy
- ☐ Sports Medicine
- ☐ Thoracic
- ☐ Trauma
- ☐ 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 exclusion 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

Provider Name: _____

Non-Delegable Responsibility:
Each individual who is an employee or agent of a protected entity of the SIP has a non-delegable responsibility to report to the SIP 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.

Circumstances Required to be Reported:
Recognizing that no definition of a reportable event 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 treatment, therapy, or surgery:

1. Total or partial loss of limb, or loss of the use of a limb
2. Sensory organ or reproductive organ impairment
3. Any injury to any part of the anatomy not undergoing treatment
4. Disability or disfigurement
5. Any assertion by a patient or patient's family that he/she has been medically injured
6. Misdiagnosis of a patient's condition resulting in mortality or increased morbidity
7. Any birth of a term baby that is stillborn or expires shortly after delivery
8. Any shoulder dystocia resulting in a fracture or other injuries
9. Any assertion by the patient/family that no consent for treatment (medical/surgical) was given
10. Any assertion or evidence that the patient was sexually abused, raped, or otherwise sexually assaulted
11. Medication errors leading to injury, death, or higher level of care
12. Retained foreign body incidents
13. Wrong site, wrong patient, wrong procedure
14. Any incident that results in an unexpected death, brain or spinal damage, or any other injury not referenced above
15. Any other unexpected adverse condition or outcome that you feel could result in a claim

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 that when in doubt, report.

WHEN & HOW TO CONTACT SIP

As a covered Healthcare Liability Self-Insurance Program (SIP) provider, it is essential and expected that you notify us immediately if:

- **You were involved, or alleged to have been involved, in an event while delivering healthcare services that may have caused or resulted in an injury (real or perceived) to a patient**
- **You received a complaint, legal notice, or licensure investigation notice related to your delivery of healthcare services**
- **You received a subpoena for deposition or medical records**
- **Please use our Incident Reporting Requirements above for additional examples of when to contact SIP and the services provided or review MY FL SIP.org.**

The Self-Insurance Program provides twenty-four-seven support and coverage for our covered healthcare providers. Our office hours are Monday–Friday from 8:00AM to 5:00PM, with after-hours support at all times to report an event/circumstance involving patient care that requires immediate attention. Simply call our main line … 352-273-7006 or 844-MY FL SIP … a SIP staff member is always available to assist!

We encourage you to download our "MY FL SIP" app for immediate access when you most need us. No more wondering how to contact us! With the app, we are only two clicks: One … click on the app for a redirect to our website home page that contains our office phone number. Two …. click on the office phone number and it will connect you to a SIP expert. Easy as that!

AUTHORIZATION FOR RELEASE OF INFORMATION

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

Florida State University College of Medicine 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 Program, 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.

_____

Provider Signature

Print Provider Name: _____

Date: _____

Florida State University College of Medicine Self-Insurance Program (SIP)

PROFESSIONAL LIABILITY QUESTIONNAIRE

PROVIDER 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. If any material change occurs during the term of my employment/appointment, I agree to notify Insurance Services of the Self-Insurance Program.

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

_____
Provider Signature

Print Provider Name: _____

Date: _____

PROVIDER: You are required to attach a copy of your C.V. **Be sure to explain all gaps in employment history greater than 3 months.**

EMPLOYER REPRESENTATIONS: Dean of College or Director of Service

I hereby declare that the Provider's statements and responses in this questionnaire have been reviewed, verified and are correct. I further represent that if any material change occurs during this Provider's employment/appointment, I will timely notify Insurance Services of the Self-Insurance program via the Participant Management portal or email. Finally, I understand that this questionnaire is for FS 1004.24 FBOG HEIC and self-insurance privileged and confidential underwriting purposes and does not meet participants independent credentialing or other required hiring background, screening, and/or onboarding processes.

_____
Dean/Chair/Director Signature (or Appointed Designee)

Print Dean/Department Chair/Director Name: _____

Title: _____

Date: _____

DEPARTMENT/UNIT/SERVICE: Please scan and e-mail **FULLY EXECUTED and COMPLETED** questionnaire, as well as all required attachments (CV, Authorization and Release of Information, and underwriting explanations), to fsuisosip@mail.ufl.edu, or fax documents to (352) 273-5424.

UNDERWRITING FORM - CLAIM SUPPLEMENT

Provider Name: _____

If you answered YES to question 7 and/or 8 under the Underwriting Information section of this questionnaire, please complete a Claim Supplement for each claim, suit, and judgment against you. If N/A , please initial here _____.

Patient (or Plaintiff) Name: _____ Date of Incident: _____

Date you became aware of this potential or actual malpractice claim? _____

How did you become aware of this claim?

_____

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

_____

Provide a summary of the allegations or potential allegations, the alleged or potentially alleged injuries/damages, and your involvement in the care of the patient.

If the claim has been resolved, provide the date the case was settled and the amount of the settlement that was attributed to the care you provided.

_____

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.