



## INDIANA PATIENT'S COMPENSATION FUND

### Employee Information

8. Employed Physicians & Surgeons (MDs and DOs) sharing limits (not contracted).     YES    NO

*If yes, please complete the following Employee Information section in full. Do not list full time administrative employees. All sections must be complete. If the answer is No, None or NA, please indicate this on the application.*

To qualify for the Newly Licensed Physician discounts, the physician must have either completed a residency program or a fellowship program in their medical specialty or fulfilled a military obligation in remuneration for medical school tuition. These discounts only apply for the immediate 2 years following the completion of the above.

To qualify for the Medical School Faculty Member discount, the physician must spend at least 70 percent of their time devoted to research and teaching for a Nationally Accredited College of Medicine.

Name and Degree (MD or DO)	Specialty	Sub-specialty	Surgery <input type="checkbox"/> None <input type="checkbox"/> Minor <input type="checkbox"/> Major	OB <input type="checkbox"/> Y <input type="checkbox"/> N
Maximum # of hours worked in any given week including on-call hours	Qualified for Newly Licensed Physician Discount <input type="checkbox"/> Yes <input type="checkbox"/> No If yes <input type="checkbox"/> 1 <sup>st</sup> year or <input type="checkbox"/> 2 <sup>nd</sup> year		Qualified for Medical School Faculty Member Discount <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name and Degree (MD or DO)	Specialty	Sub-specialty	Surgery <input type="checkbox"/> None <input type="checkbox"/> Minor <input type="checkbox"/> Major	OB <input type="checkbox"/> Y <input type="checkbox"/> N
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**INDIANA PATIENT'S COMPENSATION FUND**

**HOSPITAL EXPOSURE WORKSHEET FOR SURCHARGE CALCULATION**

Name of Hospital: \_\_\_\_\_

License Number: \_\_\_\_\_

List all facilities and/or services operated under the hospital license as identified on the Department of Health Application for License to Operate as a Hospital (**this section must be completed**):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<b>CATEGORY</b>	<b>EXPOSURE</b>
Provide # of Beds Maintained	
	Hospital (Acute care and Intensive Care)
	Mental Health/Rehabilitation
	Extended Care/Intermediate Care/Residential
	Nursing Home/Critical Extended Care
	Health Institution/Assisted Living
	Bassinets
# of Outpatient Visits	
	Emergency Room
	Clinics/Other
	Mental Health/Rehabilitation
	Health Institution
	Home Health Care
# of Surgeries/Births	
	Births
	Outpatient Surgeries
	Inpatient Surgeries
	# of Employed Physicians Sharing Limits

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## IMPORTANT Please Read Carefully and Sign

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By completing this application for professional liability as the authorized representative of the applicant, I hereby affirm that all entities and employees seeking coverage are licensed to provide professional services in their specialty in the state of Indiana. I do hereby apply for coverage as a self-insured hospital and warrant the above statements and answers. I also authorize the release of claim and suit information from any prior insurer.

The Medical Protective Company is the appointed "Risk Manager" for IRMLA and is providing this application solely under those auspices. As a result, this application for insurance is provided solely for the purpose of evaluating the applicant's surcharge quotation for the Indiana Patient's Compensation Fund and should not be seen as an offer of insurance from The Medical Protective Company or IRMLA.

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Signature of Authorized Representative

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Title

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Date of Signature

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Printed Name of Authorized Representative

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Telephone Number

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## IMPORTANT: This application must be signed by both the applicant and the producer

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Signature of Producer

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Indiana P & C License Number

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Date of Signature

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Name of Agency/ Independent Agent

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Telephone Number

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Agent's IRS Number

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Fax Number

---

E-Mail address

---

Agency Mailing Address

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City

---

State

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Zip