FINANCIAL RESPONSIBILITY ATTESTATION FORM

Financial responsibility options are divided into two categories, coverage and exemptions. Choose only one option of the ten provided pursuant to s.458.320, Florida Statutes.

OPTION 1: FINANCIAL RESPONSIBILITY COVERAGE

_____ I do not have hospital staff privileges and I have established an irrevocable letter of credit or an escrow account in an amount of $100,000/$300,000, in accordance with Chapter 675, F.S., for a letter of credit and s.625.52, F.S., for an escrow account.

_____ I have hospital staff privileges and I have established an irrevocable letter of credit or an escrow account in an amount of $250,000/$750,000, in accordance with Chapter 675, F.S., for a letter of credit and s.625.52, F.S., for an escrow account.

_____ I do not have hospital staff privileges and I have obtained and maintain professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000 from an authorized insurer as defined under s.624,05, F.S., from a surplus lines insurer as defined under s.626.914(2), F.S., from a risk retention group as defined under s.627.942(9), F.S., from the Joint Underwriting Association established under s.627.351(4), F.S., or through a plan of self insurance as provided in s.627.357, F.S.

_____ I have hospital staff privileges and I have professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s.624.09 F.S., from a surplus lines insurer as defined under s.626.914(2) F.S., from a risk retention group as defined under s.627.942(9) F.S., from the Joint Underwriting Association established under s.627.351(4) F.S., or through a plan of self insurance as provided in s.627.357 F.S.

_____ I have elected not to carry medical malpractice insurance, however, I agree to satisfy any adverse judgments up to the minimum amounts pursuant to s.458.320(5)(g)1 F.S. or s.459.0085(5)(g)1 F.S. I understand that I must either post notice in the form of a "sign" prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided that I have decided not to carry medical malpractice insurance. I understand that such a sign or notice must contain the wording specified in s.458.320(5)(g) F.S. or s.459.0085(5)(g) F.S.

OPTION II: FINANCIAL RESPONSIBILITY EXEMPTIONS

_____ I practice medicine exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.

_____ I hold a limited license issued pursuant to s.458.317 F.S. or 459.0075, F.S., and practice only under the scope of the limited license.

_____ I do not practice medicine in the State of Florida.

_____ I meet all of the following criteria:

(a) I have held an active license to practice in this state or another state or some combination thereof for more than 15 years;

(b) I am retired or maintain part time practice of no more than 1000 patient contact hours per year;

(c) I have had no more than two claims resulting in an indemnity exceeding $25,000 within the previous five-year period;

(d) I have not been convicted of or pled guilty or nolo contendere to any criminal violation specified in Chapter 458 or 459, F.S.;

(e) I have not been subject, within the past ten years of practice, to license revocation or suspension, probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458 or 459, F.S., or the medical practice act of another jurisdiction. A regulatory agency's acceptance of a relinquishment of license stipulation, consent order or other settlement offered in response to or in anticipation of filing of administrative charges against a license shall be construed as action against a license. I understand if I am claiming an exception under this section that I must either post notice in the form of a sign, prominently displayed in the reception area or provide a written statement to any person to whom medical services are being provided, that I have decided not to carry medical malpractice insurance. I understand such a sign or notice must contain the wording specified in s.458.320(5)(g) F.S. or 459.0085(5)(g) F.S.;

_____ I practice only in conjunction with my teaching duties at an accredited medical school or its teaching hospitals. Interns and residents do not qualify for this exemption.

_____	_____	_____	_____
Name (Printed)	Name (Signature)	Date (MMDDYY)	Social Security Number

☐ Freedom Health, Inc. ☐ Optimum HealthCare, Inc.