

References- continued

2 NAME/TITLE	PHONE NUMBER
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ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE
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3 NAME/TITLE	PHONE NUMBER
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ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE
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Professional Liability Insurance Coverage

SELF-INSURED? <input type="checkbox"/> Yes <input type="checkbox"/> No	NAME OF CURRENT MALPRACTICE INSURANCE CARRIER OR SELF-INSURED ENTITY
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ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE
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PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
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AMOUNT OF COVERAGE PER OCCURRENCE	AMOUNT OF COVERAGE AGGREGATE	TYPE OF COVERAGE <input type="checkbox"/> Individual <input type="checkbox"/> Shared	LENGTH OF TIME WITH CARRIER
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NAME OF PREVIOUS MALPRACTICE INSURANCE CARRIER IF WITH CURRENT CARRIER LESS THAN 5 YEARS
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AMOUNT OF COVERAGE PER OCCURRENCE	AMOUNT OF COVERAGE AGGREGATE	TYPE OF COVERAGE <input type="checkbox"/> Individual <input type="checkbox"/> Shared	LENGTH OF TIME WITH CARRIER
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Call Coverage

☐ See attached list of hospital staff within my department I utilize for call coverage.

PLEASE LIST NAMES OF COLLEAGUE(S) PROVIDING REGULAR COVERAGE AND HIS OR HER SPECIALTIES.

Name:	Specialty:
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Name:	Specialty:
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Name:	Specialty:
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Name:	Specialty:
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Name:	Specialty:
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PLEASE LIST FULL NAMES OF ALL PARTNERS IN YOUR PRACTICE. ☐ CHECK THIS BOX AND ATTACH LIST FOR LARGE GROUP.

Name:	Name:
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Name:	Name:
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Name:	Name:
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Name:	Name:
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