LOUISIANA PREMIER PHYSICIANS PROGRAM

APPLICATION FOR PHYSICIANS' AND SURGEONS' PROFESSIONAL LIABILITY INSURANCE

Please type or print in black ink. Applicant must personally complete this application. Please be sure to complete and attach all required information (See list on page 9)

As a licensed physician or surgeon, the undersigned hereby makes application for insurance with the above company and in connection with said application hereby furnishes the company with the Information that follows or is attached hereto:

A. GENERAL INFORMATION SECTION

Todays Date

Physician's Name | Practice Entity Name

Office Address (street, city, state, zip)

Billing Address (street or P.O. Box, city, state, zip)

Home Address (street, city, state, zip)

Other Locations To Be Covered (include addresses)

Home Phone Number | Office Phone Number

Fax Number | E-mail

Social Security No. | Federal Tax I.D. No.

LA License No. UPIN

Medicare/Medicaid No. State Narcotics No. DEA No.

Years in practice Years at this location

B. GENERAL INSURANCE/CLAIMS INFORMATION

Desired Effective Date

Policy Limit: $100,000 medical incident/$300,000 annual aggregate

Excess Coverage Desired (excess of $500,000 medical incident/ $500,000 aggregate)
❑$500,000 medical incident/ $500,000 aggregate ❑$1,500,000 medical incident/$1,500,000 aggregate

Expiring Primary Coverage Premium: $ Expiring PCF Premium: $

Expiration Date:

Will you be seeking Full Prior Acts Coverage under this insurance? ❑Yes ❑No

If Yes, subject to Prior Acts Date of

***NOTE**: Full Prior Acts Coverage will be considered subject to any Extended Reporting Period (tail) coverage or Prior Acts Date on prior insurances. Any Prior Acts extension of coverage is available only to those physicians who have and will continue to practice medicine exclusively in Louisiana.*

Are you aware of any reason that your current insurance carrier will not be offering a renewal or that you will be surcharged?
❑Yes (attach details) ❑No

Have you or any entity to be insured EVER had a claim/suit go beyond Medical Review Panel Proceeding?
❑Yes (See Claims Addendum) ❑No

Do you or any entity to be insured CURRENTLY have a Medical Review Panel Proceeding pending or have knowledge of an impending complaint? ❑Yes (See Claims Addendum) ❑No

Have you or any entity to be insured reported to your current or previous insurance carrier(s) ANY circumstance, incident, claim which you believe may result in the filing of a request for medical review panel, petition, claim or suit?
❑Yes (See Claims Addendum) ❑No

C. GENERAL PRACTICE INFORMATION

Medical Specialty | PCF Class Assigned (if known)

Subspecialty (if none, enter NA) | Percentage of practice devoted to subspecialty

Do you hold any specialty board certifications? If yes, enter the name of the board certification and year. If no, enter NA

I. | Year | %

II. | Year | %

Type of practice (Entity Named Above) ❑Solo ❑Partnership ❑LLC ❑ Corporation ❑Employee ❑Other

Give names of all medical partnerships, professional medical corporations, or other medical business entities to which you are affiliated (Attach separate list if necessary)

Name | Address | Your Affiliation

Type of Entity | Year Formed

Name | Address | Your Affiliation

Type of Entity | Year Formed

Are these named entities to be insured ❑Yes ❑No
If yes, provide a copy of the formation documents for each entity (See Page 9)

Have all physicians and entities maintained uninterrupted professional liability insurance? ❑Yes ❑No (attach details)
***NOTE**: Individual practitioners shall each be required to show proof of and maintain separate insurance policies with limits at least equal to those to be provided under this policy for entity coverage to apply.*

Please provide the name of each partner, member, or shareholder; name of their insurance carrier, policy no., expiration date and % of ownership (attach list if necessary)

Name | Ins. Co. | Policy No.

Exp. Date | % of Ownership

Name | Ins. Co. | Policy No.

Exp. Date | % of Ownership

Name | Ins. Co. | Policy No.

Exp. Date | % of Ownership

Are all partners/shareholders currently licensed physicians? ❑Yes ❑No (If no, explain in Remarks)

Has there been any change in your practice or specialty in the past five years? ❑Yes ❑No

If yes, please describe

D. PHYSICIAN GENERAL INFORMATION

Are you in full time practice? (average 50 hours per week) ❑Yes ❑No (If no, explain in Remarks)

Average No. of hours per week at covered locations

If employed physician, provide name/address of employer (if other than as noted above):

Employer Name Address

Ins.Carrier/Pol. No. Policy Limits Exp. Date

Have you relocated your practice in the last 10 years? ❑Yes ❑No
Provide names/address of prior practices in which you worked and your reasons for the changes.

Are you applying for insurance to cover only part-time practice or moonlighting activities? ❑Yes ❑No
If yes, please explain in the "Remarks" section of this application.

Average number of hours per week you work?

Do you serve as a Medical Director? ❑Yes ❑No (If yes, please explain in Remarks)

Are you active in the U.S. Military? ❑Yes ❑No

Describe

Are you employed by the Government (not active in the U.S. Military Service)? ❑Yes ❑No (If yes, please explain in Remarks)

Do you perform "pro bono" work? ❑Yes ❑No (If so, explain in Remarks)

Average Hours Per Month

Are you a teaching physician? ❑Yes ❑No
If yes, indicate % of time teaching and complete information below

Teaching Appointment (1) %

Institution Name:

Address (street, city, st, zip)

Program Type:

Start Date: End Date:

Teaching Appointment (2) %

Institution Name:

Address (street, city, st, zip)

Program Type:

Start Date: End Date:

Teaching Appointment (3) %

Institution Name:

Address (street, city, st, zip)

Program Type:

Start Date: End Date:

Are you responsible for the supervision of residents, interns or fellows? ❑Yes ❑No

If yes, indicate time %

Do you work in an emergency room on a scheduled basis? ❑Yes ❑No Indicate number of hours per month devoted to hospital emergency room care

Hours per Month

Is this emergency room care: For your own patients only? ❑Yes ❑No
Required for staff privileges? ❑Yes ❑No

Other-please describe

E. LICENSE AND EDUCATION INFORMATION

Specify states where you have been or are currently licensed

State Year License Number ❑Permanent ❑Temp.* (attach copy) ❑Active

State Year License Number ❑Permanent ❑Temp.* (attach copy) ❑Active

State Year License Number ❑Permanent ❑Temp.* (attach copy) ❑Active

Undergraduate	Institution/ Location	Degree	Completion Year	From	To
Medical School	Institution/ Location	Degree	Completion Year	From	To
Internship	Location	Type	Completion Year	From	To
Residency	Location	Type	Completion Year	From	To
Fellowship	Location	Type	Completion Year	From	To
Graduate	Institution/Location	Degree	Completion Year	From	To
Postgraduate	Institution/Location	Degree	Completion Year	From	To

If a foreign medical school graduate, are you certified by the Educational Council for Medical School Graduates or Fifth Pathway? ❑Yes ❑No

If yes, which certificate Year of Certification

Have you ever been delinquent or had a lapse in satisfying continuing education requirements? ❑Yes ❑No (If yes, describe in Remarks)

F. SUPPLEMENTAL PRACTICE INFORMATION

What call arrangements have you made and what are the qualifications of the person(s) sharing your calls?

Does the person sharing your calls purchase professional liability insurance? ❑Yes ❑No

Do you or your practice entity employ or supervise any of the following:

Licensed Physician Assistant ❑Yes ❑No Indicate # ____ Licensed Surgical Assistant ❑Yes ❑No Indicate #_____

Licensed Nurse Practitioner (not LPN) ❑Yes ❑No Indicate # _____

Cert. Reg. Nurse Anesthetist (CRNA) ❑Yes ❑No Indicate # ____

Nurse Midwife ❑Yes ❑No Indicate # _____ Other-Please list in "Remarks" ❑Yes ❑No Indicate # _____

NOTE: *If you answered yes to any part of the above question and you want to insure these medical professionals under your professional liability policy, please attach list of names, category and years of experience. If such individuals also maintain their own professional liability, please attach copies of certificates of insurance.*

Are any independent contractors utilized? ❑Yes ❑No (If yes, provide certificates of insurance)

Describe your practice mix, i.e., surgical to non-surgical, city or rural, welfare or private pay, etc. (attach separate sheet if necessary)

Do you market, advertise or practice medicine outside Louisiana? ❑Yes ❑No

If yes, explain

Do you maintain recovery beds for overnight patients at any practice facility? ❑Yes ❑No

Do you dispense drugs in your office? ❑Yes ❑No

If yes, describe any restrictions that are considered standard for your practice? (attach separate sheet if necessary)

Have inquiry or charges been made against you for alleged fraud or inappropriate fees? ❑Yes ❑No

Has any hospital or medical staff ever restricted or revoked your privileges or invoked probation (excluding minor medical recordkeeping infractions)? ❑Yes ❑No

Have you ever had your license revoked, suspended, or subjected to probation/restrictions or are you aware of any circumstances that might lead to such? ❑Yes ❑No

Has your membership in any medical association or society ever been refused, suspended, revoked, surrendered or been censured? ❑Yes ❑No

Have you ever been treated for alcoholism, substance abuse or mental illness? ❑Yes ❑No

Have you volunteered or been asked to participate in an impaired physician's health program? ❑Yes ❑No

Have you now or ever had a chronic illness or physical defect that impairs or could tend to impair your ability to practice medicine? ❑Yes ❑No

Have you pleaded guilty, nolo contendere or been convicted of a crime ? (other than motor vehicle violation) ❑Yes ❑No

Have fee complaints or professional relations complaints been registered against you with your medical society/association or state licensing authority within the past five years? ❑Yes ❑No

Has your professional liability insurance ever been cancelled, non-renewed, restricted, surcharged; or has your professional liability insurer ever asked you not to renew your policy? ❑Yes ❑No

Has any insurance carrier ever declined professional liability insurance to you? ❑Yes ❑No

Has any petition, claim or suit for alleged malpractice ever been brought against you? ❑Yes ❑No

Are you aware of any circumstances that might reasonably lead to such a petition, claim or suit? ❑Yes ❑No

Are you aware of any circumstances that might change any of the above answers? ❑Yes ❑No

NOTE: *If you answered yes to any of the above questions please provide details in the Remarks section or attach a separate sheet and provide the following information:*

(1) For each complaint, claim, panel petition or suit please complete and attach CLAIM ADDENDUM.
(2) A copy of the petition filed against you, if available.
(3) If you think it will help in the evaluation of the claim, include a copy of the complete hospital chart, your office records, and a complete copy of all medical records (hospital, ambulatory care, office, etc.) pertinent to the claim. We may ask for additional information as needed. Please be as thorough as possible in order for the Underwriting Department to give your application a prompt review.

REMARKS

PLEASE USE THIS OR SEPARATE SHEETS TO PROVIDE INFORMATION. PLEASE ALSO INDICATE HERE WHAT ADDITIONAL SHEETS OR INFORMATION PAGES ARE ATTACHED TO THIS APPLICATION.

I hereby declare that all statements and answers herein and provided for consideration of insurance are full, complete, and true to the best of my knowledge and belief and that no material circumstance or information concerning the subject matter of the questions asked has been withheld or omitted. The statements made and information provided is also based on query of Executive Officers (including office manager, human resources manager or compliance manager or their equivalent). I understand that the statements and information provided will be relied upon by insurer, reinsurers and representatives and are material in determining not only whether insurance coverage will be issued or renewed, but also to determine correct classification and premium calculations.

I hereby authorize release of my name, business address, policy and premium information by insurer, reinsurer or their representatives or designees. I authorize any professional societies, prior or present business or medical associates, licensing boards, hospitals, government entities, corporations, partnerships, organizations, institutions or persons that may have any record or knowledge concerning any of the statements and answers made herein to release such information upon its request. I authorize the use of a copy of this authorization in place of the original. I understand that the coverage provided is subject to a program aggregate limit as well as sublimits per certificate holder as per the master policy on file with the Company.

Signing this application does not bind the insurer to issue a policy of insurance. However, it is agreed that this application and including its attachments shall form the basis of the policy for acceptance and will be attached thereto and be a part thereof. It is further acknowledged and agreed by the applicant that he/she has received and reviewed a copy of the Operating Agreement of Louisiana Premier Physicians Program, L.L.C., a Louisiana limited liability company operating as a risk purchasing group for the insurance being applied for, and that, upon acceptance of this application, the applicant will become a party to such Operating Agreement and will be a Class A-1 Member of Louisiana Premier Physicians Program, L.L.C. in accordance with and subject to the terms of such Operating Agreement.

Applicant Signature Date

Louisiana Revised Statute 40:1424, provides, in part, the following: "B. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

LIST OF ATTACHMENTS REQUIRED

(1) Current/Prior Professional Liability Insurance Information
(2) Specialty/Procedures Form
(3) Hospital Affiliation Form
(4) Related Practitioner Information Form
(5) Certificate of Insurance Request Form
(6) Articles of Partnership, Articles of Organization, or Articles of Incorporation for each entity that is to be covered.
(7) Copy of your current policy showing the retroactive and/or prior acts date
(8) Current certificate of enrollment from Louisiana Patients Compensation Fund (PCF)
(9) Copy of your most recent PCF surcharge notice (with experience rating information if applicable)
(10) Copy of all Collaborative Practice Agreements with APRNs you supervise

110 Veterans Boulevard, Suite 360 • Metairie, Louisiana 70005-4930
Telephone: 504 834-6240 • Toll Free: 877 834-6240 • Facsimile: 504 836-2860
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Administered by: Global Benefits, Incorporated

Lexington Insurance Company

LOUISIANA PREMIER PHYSICIANS PROGRAM

MEDICAL OR SURGICAL PROCEDURES FORM

Please indicate whether you perform any of the following:

ANESTHESIA: ❑General ❑Spinal ❑Epidural ❑Consious sedation without anesthesia personnel

❑Assisting in Minor Surgical Procedures

❑Perform Minor Surgical Procedures

MINOR SURGERY & PROCEDURES—Includes operations and procedures not considered to be major surgery, involving primary treatment of limited abnormalities, injuries, and infections of the skin and superficial tissue, usually using local anesthesia and predominantly performed on an outpatient basis. It includes, but is not limited to, the following list. Check all applicable:

❑No procedures—only consulting or diagnostic ❑Acupuncture—other than acupuncture anesthesia

❑Angiography ANGIOPLASTY: ❑a. Coronary ❑b. Peripheral

❑Bone Fractures: closed treatment ❑Bone Marrow aspiration

BRONCHIAL: ❑Fiberoptic bronchoscopy ❑Pneumatic or mechanical esophageal dilation (not with bougie or olive)

❑Cancer chemotherapy

CATHERIZATION: ❑a. Cardiac ❑b. Transarterial ❑c. Occasional insertion of pulmonary wedge, recording catheter, or temporary pacemakers

❑d. Transvenous ❑e. Umbilical cord catherization for diagnostic purposes or for monitoring blood gases in newborns receiving oxygen (other than emergency for transport)

❑Circumcision ❑Adult Circumcision

❑Cosmetic injections—specify type ❑Cosmetic/reconstructive skin flaps and skin graft

CRYOSURGERY: ❑a. On benign dermatological lesions ❑b. Other _____

DERMATOLOGICAL: ❑Dermabrasion ❑Hair Transplant ❑Laser therapy-specify type _____
❑Diagnostic sonography

DIGESTIVE: ❑Interventional endoscopy—specify _____ ❑Colonoscopy _____

❑Electroshock therapy (psychiatric)

LIPOSUCTION: ❑a. Flanks/Buttocks/Abdomen/Thighs ❑b. Large Volume ❑c. Limited to Head/Neck
❑d. Tumescent ❑e. Ultrasonic Assisted Lipoplasty

NEEDLE BIOPSY: ❑a. Lung, liver, kidney, or prostate ❑b. Other—specify type _____
❑c. Percutaneous biopsy or diagnostic study of organs or structures other than those above the superficial fascia

❑Nerve Blocks, therapeutic—specify in "Remarks" ❑Pain Management—specify in "Remarks"

❑Radiopaque contrast material injections into blood vessels, lymphatic, sinus tracts, and fistulae ❑Vasectomy

SPINAL: ❑Myelography ❑Discogram

SUPERFICIAL PROCEDURES: ❑Incisions of boils and superficial abscesses ❑Suturing of skin and superficial fascia

WEIGHT CONTROL TREATMENT: ❑Weight Control Treatment—diet only weight ❑Control Treatment—drugs
❑Other (describe)

❑Assist in Major Surgery (Check all applicable procedures below)

❑Perform Major Surgery (Check all applicable procedures below)

Major Surgery—Includes operation procedures in or upon any body cavity, including cranium, thorax, abdomen, pelvis; any other operations or procedures which, because of the condition of the patient or the length or circumstances of the operation, present a distinct increase in morbidity and/or mortality. It also includes, but is not limited to, the following list. Check all that are applicable:

❑Amputations—specify body location: _____

BIOPSY: ❑a. Breast ❑b. Endometrial ❑c. Liver ❑d. Lung
❑e. Lymph Gland ❑f. Lymph Node just above clavicle ❑g. Scalene Node

BLOCKS: ❑a. Celiac Plexus ❑b. Cervical Epidural ❑c. Cervical Facet Joint ❑d. Lumbar Epidural
❑e. Lumbar Facet Joint ❑f. Lumbar Sympathetic ❑g. Peripheral Nerve ❑h. Retrobulbar
❑i. Spinal Nerve ❑j. Stellate Ganglion

BONE FRACTURES: ❑a. Operative treatment—specify body location: _____

❑b. Closed manipulation-general or regional anesthesia—specify body location: _____

GYNECOLOGICAL/OBSTETRICAL PROCEDURES: Abortions: ❑a. 1st Trimester ❑b. 2nd Trimester ❑c. 3rd Trimester

❑Caesarean sections ❑Cervical Conization—specify type: _____
❑Cervical Laminectomy ❑Culdocentesis ❑Ectopic Pregnancy ❑Fertility or reproductive surgery
❑Forceps delivery other than outlet forceps ❑General Pelvic Examination ❑Home Delivery
❑Hydrocelectomy ❑Hysterectomy-Abdominal ❑Hysterectomy-Vaginal
❑Insertion and Removal of IUD
Dilation and currettements other than emergency: ❑a. Diagnostic ❑b. Sterilization ❑c. Therapeutic
❑Oophorectomy ❑Salpingectomy ❑Tubal Ligation ❑Vaginal Delivery

JOINTS: ❑Inradiscal Electrothermal Therapy ❑Tendon Repair ❑Fluoroscopy
❑Laparoscopy ❑Laparoscopic Cholecystectomy

❑Minimal invasive endoscopic surgery—specify type: _____

❑Obesity surgery—specify type: _____

❑Orchidectomy

OPHTHAMOLOGICAL: ❑Laser Surgery (Ophthalmology w/o Retinal Detachment) ❑Lid Repair ❑Cataract Surgery
❑Corneal Transplant ❑Retinal Detachment Surgery

PLASTIC SURGERY: ❑Cosmetic—specify: _____

❑Reconstructive—specify: _____

❑Facial—specify: _____

❑Breast Augmentation ❑a. Breast Augmentation-transumbilical ❑Penile implants ❑Permanent Lash Liner

PROCTOLOGY: ❑Hemmorhoidectomy-Other than Ligation ❑Herniorraphy ❑Anal Fissurectomy

SPINE SURGERY: Primary: ❑a. Cervical ❑b. Thoracic ❑c. Lumbar ❑d. Spinal instrumentation
Reoperative: ❑a. Cervical ❑b. Thoracic ❑c. Lumbar ❑d. Spinal instrumentation
❑Percutaneous disc surgery

❑Tonsillectomies and/or adenoidectomies ❑Vein Stripping

Lexington Insurance Company

LOUISIANA PREMIER PHYSICIANS PROGRAM

RELATED PRACTITIONER INFORMATION

For Physicians and Practitioners in your Group or used for Sharing Calls
(If you need additional space, photocopy and attach additional sheets.)

Name: _____ In your group? ❑Yes ❑No Sharing Call? ❑Yes ❑No

Group Name: _____ Specialty: _____

Address: _____

Board Certified: _____ License #: _____ License State: _____

Name: _____ In your group? ❑Yes ❑No Sharing Call? ❑Yes ❑No

Group Name: _____ Specialty: _____

Address: _____

Board Certified: _____ License #: _____ License State: _____

Name: _____ In your group? ❑Yes ❑No Sharing Call? ❑Yes ❑No

Group Name: _____ Specialty: _____

Address: _____

Board Certified: _____ License #: _____ License State: _____

Name: _____ In your group? ❑Yes ❑No Sharing Call? ❑Yes ❑No

Group Name: _____ Specialty: _____

Address: _____

Board Certified: _____ License #: _____ License State: _____

Louisiana Revised Statute 40:1424, provides, in part, the following: "B. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

Lexington Insurance Company

LOUISIANA PREMIER PHYSICIANS PROGRAM

HOSPITAL AFFILIATIONS

Name of Applicant: _____

Practice Name: _____

List in chronological order, with dates and addresses, all present and past hospital staff appointments. Do not list hospitals which are part of your internship(s) and residency(ies) since you only rotate through these facilities as part of your training. If you need additional space, please make photocopies of this sheet and attach.

Facility: _____ Primary? ❑Yes ❑No Chief of Service: _____

Address: _____

Department: _____ Specialty: _____ Staff Status: _____

Start Date: _____ End Date: _____

Facility: _____ Primary? ❑Yes ❑No Chief of Service: _____

Address: _____

Department: _____ Specialty: _____ Staff Status: _____

Start Date: _____ End Date: _____

Facility: _____ Primary? ❑Yes ❑No Chief of Service: _____

Address: _____

Department: _____ Specialty: _____ Staff Status: _____

Start Date: _____ End Date: _____

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***Lexington** Insurance Company*

LOUISIANA PREMIER PHYSICIANS PROGRAM

CURRENT/PRIOR INSURANCE ADDENDUM

Name of Applicant: _____

Practice Name: _____

Please list all current and previous liability insurance carriers. Please make photocopies and attach, if needed.

Current Carrier: _____ Policy No.: _____

Amount of Coverage: Per Claim: _____ Aggregate: _____

Start Date: _____ End Date: _____

Retroactive/Prior Acts Date: _____ Occurrence Form _____

Previous Carrier: _____ Policy No.: _____

Amount of Coverage: Per Claim: _____ Aggregate: _____

Start Date: _____ End Date: _____

Retroactive/Prior Acts Date: _____ Occurrence Form _____

Reason for Change: _____

Previous Carrier: _____ Policy No.: _____

Amount of Coverage: Per Claim: _____ Aggregate: _____

Start Date: _____ End Date: _____

Retroactive/Prior Acts Date: _____ Occurrence Form _____

Reason for Change: _____

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LOUISIANA PREMIER PHYSICIANS PROGRAM

CLAIM/SUIT/COMPLAINT ADDENDUM

If additional space is required please photocopy this form as needed. Please type or print in black ink.
NOTE: additional documentation (office/hospital records) may be requested by the underwriting department.

Name of Applicant _____

Patient's Initials: _____ Age: _____ Sex: _____ Date of Incident _____

Insurance company defending your claim: _____ Policy #: _____

Location of incident (Hospital, Office): _____ City: _____ State: _____

Procedures performed: _____

Allegations and narrative description of the medical facts and your involvement (attending, consultant, ER physician, primary surgeon, surgical assistant, resident, etc.). If you already have a written narrative, please attach it to this form.

_____

_____

Co-Defendants: _____

PRESENT STATUS: Suit filed: ❑Yes ❑No If Yes, Month: _____ Year: _____

Court Trial: ❑Yes ❑No Verdict: ❑Plaintiff Verdict ❑Defense Verdict

Medical Review Panel date: _____ Panel Opinion: ❑Favorable ❑Unfavorable ❑Issue of Fact

Settlement out of court: ❑Yes ❑No If Yes: Month: _____ Year: _____ Amount: _____

❑Claim settled without indemnity payment on your behalf Amount: _____

❑Claim is pending ❑Claim dismissed or withdrawn

Amount in reserve by insurance company: $ _____

Total amount paid to claimant on your behalf: $ _____

Total amount paid to claimant for all defendants: $ _____

The Applicant understands that the information submitted herein becomes part of the Professional Liability Application for insurance and all information are true and correct.

Applicant Signature in full _____ Date _____

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LOUISIANA PREMIER PHYSICIANS PROGRAM

CERTIFICATES OF INSURANCE

NAME OF APPLICANT: _____

PRACTICE NAME: _____

List hospitals where you hold or are applying for staff privileges. Place an X in front of each hospital requiring a certificate of insurance. Also list other entities (i.e., credentialing organizations, managed care entities, etc.) requiring certificates of insurance.

Institution Name	Address	City	State	Zip Code	Phone Number
Institution Name	Address	City	State	Zip Code	Phone Number
Institution Name	Address	City	State	Zip Code	Phone Number
Institution Name	Address	City	State	Zip Code	Phone Number
Institution Name	Address	City	State	Zip Code	Phone Number

Request for Certificates of Insurance

Institution Name	Address	City	State	Zip Code	Phone Number
Institution Name	Address	City	State	Zip Code	Phone Number
Institution Name	Address	City	State	Zip Code	Phone Number
Institution Name	Address	City	State	Zip Code	Phone Number
Institution Name	Address	City	State	Zip Code	Phone Number