NURSE PRACTITIONER PROFESSIONAL LIABILITY

Licensing, practice, procedures, insurance, and patient-care controls.

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1. Applicant and Contact Information

Full name *

Date of birth

National Provider Identifier (NPI)

Requested effective date

Mailing address

City / State / ZIP

Email *

Phone *

2. Licensing and Certification

State(s) licensed

License number(s)

Date of initial licensure

License expiration date

Are you nationally certified? ☐ Yes ☐ No

Certifying organization

Certification / expiration

Has any license, certification, DEA registration, or privilege been restricted or investigated? ☐ Yes ☐ No

If Yes, explain dates, jurisdiction, status, and outcome:

3. Practice and Employment Details

Are you currently practicing as a nurse practitioner? ☐ Yes ☐ No

Primary specialty:

☐ Family ☐ Adult / gerontology ☐ Pediatric ☐ Psychiatric / mental health

☐ Women's health ☐ Acute care ☐ Emergency / urgent care ☐ Other

Hours worked weekly

Patients per week

Years as an NP

Employer / practice name

Employment start date

Practice setting:

☐ Private practice ☐ Group practice ☐ Hospital ☐ Clinic

☐ Telemedicine ☐ Home health ☐ Long-term care ☐ Other

Are you self-employed or an independent contractor? ☐ Yes ☐ No

Do you supervise or delegate duties to others? ☐ Yes ☐ No

Describe employment, independent work, supervision, and collaborating physician arrangements:

4. Clinical Activities and Procedures

Do you prescribe medications? ☐ Yes ☐ No

Do you prescribe or administer controlled substances? ☐ Yes ☐ No

Do you perform invasive, surgical, cosmetic, or pain-management procedures? ☐ Yes ☐ No

Do you provide services by telemedicine or across state lines? ☐ Yes ☐ No

Do you provide services outside your standard scope of practice? ☐ Yes ☐ No

Are you involved in clinical research or trials? ☐ Yes ☐ No

Describe procedures, medications, telemedicine, research, or other Yes answers:

5. Patient Care and Risk Management

Are accurate and complete patient records maintained?	☐ Yes	☐ No
Are procedure-specific informed-consent forms used and retained?	☐ Yes	☐ No
Are diagnostic results, referrals, and follow-up care tracked to completion?	☐ Yes	☐ No
Are patient complaints and adverse events documented and reviewed?	☐ Yes	☐ No
Are medication reconciliation and allergy checks completed?	☐ Yes	☐ No
Are controlled-substance prescribing and monitoring protocols documented?	☐ Yes	☐ No
Are infection-control and exposure-control protocols followed?	☐ Yes	☐ No
Are emergency response procedures and equipment available when needed?	☐ Yes	☐ No
Are chaperone and mandatory-reporting procedures followed where applicable?	☐ Yes	☐ No
Are telemedicine identity, location, consent, and emergency procedures documented?	☐ Yes	☐ No
Is continuing medical education completed and documented?	☐ Yes	☐ No
Is professional liability coverage verified for all supervised or contracted clinicians?	☐ Yes	☐ No

CME hours annually

Controlled-substance %

Telemedicine %

Explain any No answers, exceptions, or planned corrective actions:

6. Other Professional Activities

Mark every applicable activity:

- ☐ Teaching / precepting
- ☐ Medical director
- ☐ Expert witness
- ☐ Volunteer services
- ☐ Administrative work
- ☐ Moonlighting / locums

Describe additional professional activities and estimated hours or revenue:

7. Current Insurance and Coverage Requested

Do you currently have professional liability insurance? ☐ Yes ☐ No

Current carrier

Policy number

Per-claim limit

Aggregate limit

Expiration date

Current policy type / request:

☐ Claims-made ☐ Occurrence ☐ New coverage

☐ Renewal ☐ Tail coverage ☐ Prior acts

Has coverage ever been cancelled, declined, non-renewed, or restricted? ☐ Yes ☐ No

8. Claims and Known Circumstances

Have you had a malpractice claim, suit, demand, or board complaint? ☐ Yes ☐ No

Are you aware of any act, incident, or circumstance that may result in a claim? ☐ Yes ☐ No

For each Yes answer, provide date, allegation, claimant, status, amount paid or reserved, and outcome:

9. Supporting Documents

Mark documents included:

☐ Current declarations ☐ Five-year loss runs ☐ License / certification

☐ CV / professional history ☐ Procedure list ☐ Claim details

10. Applicant Certification and Signature

The applicant represents that the information provided is true, complete, and accurate to the best of the applicant's knowledge. This questionnaire does not bind coverage; all terms are subject to carrier underwriting and policy language.

Signature / typed name *

Date *

MAD Insurance representative

Agent phone / email