

REGISTERED NURSE PROFESSIONAL LIABILITY

Licensing, nursing practice, patient care, and risk controls.



iPhone Files/Preview: tap a square and type X.

Page 1 of 4

1. Applicant and Contact Information

Full name *

Date of birth

National Provider Identifier (NPI), if applicable

Requested effective date

Mailing address

City / State / ZIP

Email *

Phone *

2. Registered Nurse Licensure

State(s) licensed

License number(s)

Date of initial RN licensure

License expiration date(s)

Do you hold an active, unrestricted RN license in every state where you practice?

☐ Yes

☐ No

Has any nursing license, certification, or hospital privilege been restricted, investigated, suspended, or disciplined?

☐ Yes

☐ No

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

Have you been convicted of a felony or misdemeanor related to your professional practice?

☐ Yes

☐ No

If Yes, explain:

3. Nursing Practice and Employment

Are you currently practicing as a registered nurse?

☐ Yes

☐ No

Primary nursing specialty / area of practice:

Mark all specialties or nursing functions performed:

- | | | |
|---|---|---|
| ☐ Acute / critical care | ☐ Emergency / trauma | ☐ Medical / surgical |
| ☐ Operating room / perioperative | ☐ Pediatrics / neonatal | ☐ Psychiatric / behavioral health |
| ☐ Obstetrics / labor and delivery | ☐ Oncology / infusion | ☐ Home health / hospice |
| ☐ Long-term care / skilled nursing | ☐ School / camp nursing | ☐ Case management / utilization review |
| ☐ Dialysis | ☐ Rehabilitation | ☐ Public health / community |
| ☐ Telephone triage / advice line | ☐ Aesthetic / cosmetic nursing | ☐ Other |

Hours worked weekly

Patients per week

Years practicing as an RN

Employer / practice name

Employment start date

Primary practice setting(s):

- | | | |
|--------------------------------------|---|---|
| ☐ Hospital | ☐ Physician / outpatient clinic | ☐ Ambulatory surgery center |
| ☐ Home health | ☐ Hospice | ☐ Nursing home / assisted living |
| ☐ School | ☐ Correctional facility | ☐ Travel / agency staffing |
| ☐ Telehealth | ☐ Patient residence / private duty | ☐ Other |

Are you self-employed, an independent contractor, or working through a staffing agency?

☐ Yes

☐ No

Do you supervise staff, delegate tasks, or serve in a charge / management role?

☐ Yes

☐ No

Describe your employers, duties, supervision / delegation, and any independent or contract work:

Patient population / acuity and any specialty training or certifications:

4. Clinical Duties and Higher-Exposure Activities

- | | | |
|--|------------------------------|-----------------------------|
| Do you administer medications, including IV medications or high-alert drugs? | ☐ Yes | ☐ No |
| Do you handle, administer, or witness controlled substances? | ☐ Yes | ☐ No |
| Do you perform IV starts, injections, wound care, catheterization, or other invasive procedures? | ☐ Yes | ☐ No |
| Do you perform cosmetic / aesthetic services, including injectables, lasers, or energy-based treatments? | ☐ Yes | ☐ No |
| Do you provide telephone / electronic triage, treatment advice, or patient education? | ☐ Yes | ☐ No |
| Do you provide nursing services through telehealth or across state lines? | ☐ Yes | ☐ No |
| Do you delegate nursing tasks or supervise unlicensed assistive personnel? | ☐ Yes | ☐ No |
| Do you provide services outside your usual assignment, training, or documented scope? | ☐ Yes | ☐ No |

Describe procedures, medications, patient care duties, and any Yes answers (include approximate share of work):

5. Patient Care and Risk Management

- | | | |
|--|------------------------------|-----------------------------|
| Are patient records complete, timely, and maintained in an approved system? | ☐ Yes | ☐ No |
| Are assessments and changes in condition promptly documented and escalated? | ☐ Yes | ☐ No |
| Are shift handoffs, provider communications, and critical test-result follow-ups tracked? | ☐ Yes | ☐ No |
| Are medication, allergy, patient-identity, and high-alert medication checks followed? | ☐ Yes | ☐ No |
| Are infection prevention, sharps safety, and exposure-control protocols followed? | ☐ Yes | ☐ No |
| Are fall, pressure injury, and other patient-specific safety risks assessed and addressed? | ☐ Yes | ☐ No |
| Are delegation, supervision, and competency verification procedures documented? | ☐ Yes | ☐ No |
| Are complaints, medication errors, and adverse events reported and reviewed? | ☐ Yes | ☐ No |

Explain any No answers, exceptions, or corrective actions:

REGISTERED NURSE PROFESSIONAL LIABILITY

Coverage requested, insurance history, claims, and applicant certification.



Page 4 of 4

6. Other Professional Activities

Mark all that apply:

- | | | |
|---|--|--|
| ☐ Teaching / clinical instruction | ☐ Volunteer nursing | ☐ Moonlighting / per diem |
| ☐ Medical mission / international work | ☐ Nurse management / administration | ☐ Legal nurse consulting |
| ☐ Clinical research | ☐ Other | |

Describe additional activities, locations, and estimated hours or percentage of work:

7. Current Insurance and Coverage Requested

Do you currently carry individual professional liability insurance?

☐ Yes ☐ No

Current carrier

Policy number

Each claim limit

Aggregate limit

Expiration date

Coverage request:

- | | | |
|---|-------------------------------------|--------------------------------------|
| ☐ New coverage | ☐ Renewal | ☐ Prior acts |
| ☐ Extended reporting period / tail | ☐ Occurrence | ☐ Claims-made |

Has coverage ever been declined, cancelled, non-renewed, or restricted?

☐ Yes ☐ No

If Yes, explain:

8. Claims and Known Circumstances

Have you had a professional liability claim, suit, demand, incident report, or licensing-board complaint?

☐ Yes ☐ No

Are you aware of an incident or circumstance that may result in a claim?

☐ Yes ☐ No

For each Yes, provide date, allegation, claimant, status, and amounts paid / reserved:

9. Supporting Documents

Mark documents included:

- | | | |
|--|--|--|
| ☐ Current declarations page | ☐ Five-year loss runs | ☐ RN license / certifications |
| ☐ Resume / work history | ☐ Description of duties | ☐ Claim / incident details |

10. Applicant Certification and Signature

I represent that the information provided is true, complete, and accurate to the best of my knowledge. This questionnaire does not bind coverage; all terms are subject to carrier underwriting and policy language.

Applicant signature / typed name *

Date *

MAD Insurance representative

Agent phone / email