UFHealth
UNIVERSITY OF FLORIDA HEALTH

University of Florida J. Hillis Miller Health Center Self-Insurance Program
www.myflsip.org

PROFESSIONAL LIABILITY QUESTIONNAIRE

PROVIDER: Please type or print responses and answer all questions in full. If a question does not apply to you, state "none" or "N/A" (not applicable). If you require additional space for your answers, please attach additional pages.

Date of Hire or Anticipated Hire: _____

GENERAL INFORMATION

Provider Name: _____ Degree: _____

Other Legal Name(s): _____ UF Employee ID#: _____

FL Board License # (Please include prefix, e.g., ME, OS, PA, APRN): _____

Contact Information:

Cell Phone: _____ Work e-Mail: _____

Work Phone: _____ Personal e-Mail: _____

Home Phone: _____

UF/SHANDS INSTITUTION AFFILIATION

Employer/College: _____ Department: _____

Division: _____ Employment FTE %: _____ Clinical FTE %: _____

Position Title: _____

List all UF/Shands employment-related patient care practice locations (facility name, city, state): Certificate/Facesheet Required?

_____ ◯ Yes ◯ No

_____ ◯ Yes ◯ No

_____ ◯ Yes ◯ No

UNDERWRITING INFORMATION

1. Will you be engaged in any **clinical services outside the state of Florida within course and scope of your UF/Shands employment**? ◯ Yes ◯ No

   If YES,

   Estimated annual hours dedicated to this service: _____

   List states serviced: _____

   List the facility name and city if the our of state service location(s): _____

   _____

   Describe clinical services that will be provided: _____

2. Will you be engaged in **telemedicine within course and scope of your UF/Shands employment**? (Telemedicine Definition: The practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment.) ◯ Yes ◯ No

   If YES,

   List states serviced: _____

   List the facility name and city of the location(s) from which you will be providing the telemedicine services:

   _____

   Describe the telemedicine services that will be provided: _____

UNDERWRITING INFORMATION (Continued)

Provider Name: _____

3. Has your license to practice medicine or your permit to prescribe drugs ever been denied, revoked, suspended, placed on probation, subjected to reprimand, voluntarily surrendered or in any other way limited, or has it been or is it currently under investigation? If "Yes", please attach a detailed written explanation. ◯ Yes ◯ No

4. Have you ever been or are you currently under a Consent Order? If "Yes," attach a copy of the Consent Order and its termination, if applicable. ◯ Yes ◯ No

5. Have your hospital staff privileges ever been denied, suspended, revoked, placed on probation, voluntarily surrendered or in any other way restricted, or have they been or are they currently under investigation? If "Yes," please attach a detailed written explanation. ◯ Yes ◯ No

6. Has any insurance company ever canceled, declined to issue or refused to renew your professional liability insurance, or offered such insurance only on special terms, or have you been notified of such intent? If "Yes," please attach a copy of the Cancellation Notice or Letter, if applicable. ◯ Yes ◯ No

7. Have any claims been asserted or civil actions filed against you alleging errors or omissions, or against your employer or any other entity responsible for or alleged to be responsible for your patient care activities, or have you been notified that such an action will be filed? If "Yes," please complete a Claim Supplement (form attached) for each claim and civil action. ◯ Yes ◯ No

8. Have any judgments been made against you, or any out-of-court settlements been made on your behalf, from an event alleging medical errors or omissions that was not addressed in "7." above? If "Yes," please complete a Claim Supplement (form attached) for each claim. ◯ Yes ◯ No

9. Have you ever been convicted of a criminal offense or are you under investigation for a criminal offense? If "Yes," please attach a detailed written explanation. ◯ Yes ◯ No

10. Have you been treated for alcoholism or drug addiction within the last five years? If "Yes", please attached a detailed written explanation including dates and locations of all treatments and the names of your supervising and monitoring physicians. ◯ Yes ◯ No

11. Have you incurred or become aware of having a condition that impairs your ability to practice your speciality? If "Yes," please attach a detailed written explanation. ◯ Yes ◯ No

RATING INFORMATION

Provider Name: _____

Limit your below responses to patient care that you are, or anticipate will be, providing on behalf of your employer. Please do not include information on patient care that you are or may be qualified to provide but do not anticipate you will be providing on behalf of your employer. Doing so could result in an unnecessary increase in SIP funding.

Surgery Class:

◯ **NONE** — **Includes** incision of boils & superficial fascia, suturing of minor lacerations and removal of superficial skin lesions by other than surgical excision.

◯ **MINOR** — **Includes** operations not considered to involve a risk to life, circumcisions, & non-major OB procedures. **Excludes** all surgeries and procedures that meet the criteria of major surgery.

◯ **MAJOR** — **Includes** removal of tumors, open bone fractures, amputations, removal of any gland or organ, plastic surgery, tonsillectomy, adenoidectomy, caesarean section, and any operation in or upon any body cavity, including but not limited to cranium, thorax, abdomen or pelvis or any other operation that because of the condition of the patient or the length or circumstances of the operation presents a distinct hazard to life.

Medical or Surgical Speciality:

- ☐ Anesthesiology
- ☐ Emergency Medicine
- ☐ Fam Practice/Gen Med
- ☐ Internal Medicine
- ☐ Neurological Surgery
- ☐ Neurology
- ☐ OB & Gynecology
- ☐ Ophthalmology
- ☐ Orthopaedics
- ☐ Otolaryngology
- ☐ Pathology
- ☐ Pediatrics
- ☐ Podiatry
- ☐ Psychiatry
- ☐ Radiation Therapy
- ☐ Radiology
- ☐ Surgery
- ☐ Other (define): _____

Medical or Surgical Sub-Speciality

- ☐ Abdominal
- ☐ Aerospace Medicine
- ☐ Allergy
- ☐ Bariatric
- ☐ Broncho-Esophagology
- ☐ Cardiac
- ☐ Cardiovascular Disease
- ☐ Colon & Rectal
- ☐ Dermatology
- ☐ Diabetes
- ☐ Endocrinology
- ☐ Family Practice
- ☐ Forensic Medicine
- ☐ Gastroenterology
- ☐ General
- ☐ Geriatrics
- ☐ Gynecology
- ☐ Hand
- ☐ Head & Neck
- ☐ Hematology
- ☐ Hospitalist
- ☐ Infectious Disease
- ☐ Intensive Care
- ☐ Laryngology
- ☐ Neonatology
- ☐ Neoplastic Disease
- ☐ Nephrology
- ☐ Nuclear Medicine
- ☐ Neurology
- ☐ Nutrition
- ☐ Obstetrics
- ☐ Occupational Med
- ☐ Ophthalmology
- ☐ Oral Surgery
- ☐ Orthopaedics
  - ☐ Including spine
  - ☐ Excluding spine
- ☐ Otology
- ☐ Otorhinolaryngology
- ☐ Otorhinolaryn/Plastic
- ☐ Pain Management
- ☐ Pathology
- ☐ Pediatrics
- ☐ Pharmacology, Clin.
- ☐ Physiatry
- ☐ Physical Med/Rehab
- ☐ Plastic
- ☐ Podiatry
- ☐ Preventative Med
- ☐ Psychiatry
- ☐ Psychoanalysis
- ☐ Psychosomatic Med
- ☐ Pulmonary
- ☐ Radiology
- ☐ Rheumatology
- ☐ Rhinology
- ☐ Sclerotherapy
- ☐ Other (define): _____
- ☐ Thoracic
- ☐ Trauma
- ☐ Urology
- ☐ Vascular

Medical Techniques or Procedures

- ☐ Acupuncture (other than acupuncture anesthesia)
- ☐ Angiography
- ☐ Arteriography
- ☐ Catheterization/Arterial, cardiac or diagnostic (see exclusion 1 below)
- ☐ Colonoscopy
- ☐ Discogram
- ☐ Endoscopic Retrograde Cholangiopancreatography
- ☐ Electroconvulsive Therapy
- ☐ Laparoscopy
- ☐ Lasers
- ☐ Lymphangiography
- ☐ Myleography
- ☐ Needle Biopsy (see exclusion 2 below)
- ☐ Phlebography
- ☐ Pneumatic or Mechanical Esophageal Dilation (see exclusion 3 below)
- ☐ Pneumoencephalography
- ☐ Radiation Therapy
- ☐ Radiopaque Dye Injections into blood vessels, lymphatics, sinus tracts or fistulae (see exclusion 4 below)

Exclusion 1: *Does not include occasional emergency insertion of pulmonary wedge pressure recording or temporary pacemaker, urethral caths, or umbilical cord cath for diagnostic purpose or for monitoring blood gases in newborns on oxygen*
Exclusion 2: *Does not include fine needle aspiration and does not include liver, kidney or bone marrow biopsy*
Exclusion 3: *Does not include dilation with bougie or olive*
Exclusion 4: *Not applicable to Radiologists*

INCIDENT REPORTING REQUIREMENTS

Provider Name: _____

Non-Delegable Responsibility:
Each individual who is an employee or agent of a protected entity of the SIP has a non-delegable responsibility to report to the SIP any occurrence or circumstance which has the potential of becoming a liability claim against you and/or your employer and/or the facility at which the circumstance occurred.

Circumstances Required to be Reported:
Recognizing that no definition of a reportable event will cover all circumstances and that it is often the magnitude of an injury rather than the actual quality of the care delivered that causes malpractice claims to be filed, the following conditions or incidents are among those which must be reported if they manifest while the patient is undergoing treatment, therapy, or surgery:

1. Total or partial loss of limb, or loss of the use of a limb
2. Sensory organ or reproductive organ impairment
3. Any injury to any part of the anatomy not undergoing treatment
4. Disability or disfigurement
5. Any assertion by a patient or patient's family that he/she has been medically injured
6. Misdiagnosis of a patient's condition resulting in mortality or increased morbidity
7. Any birth of a term baby that is stillborn or expires shortly after delivery
8. Any shoulder dystocia resulting in a fracture or other injuries
9. Any assertion by the patient/family that no consent for treatment (medical/surgical) was given
10. Any assertion or evidence that the patient was sexually abused, raped, or otherwise sexually assaulted
11. Medication errors leading to injury, death, or higher level of care
12. Retained foreign body incidents
13. Wrong site, wrong patient, wrong procedure
14. Any incident that results in an unexpected death, brain or spinal damage, or any other injury not referenced above
15. Any other unexpected adverse condition or outcome that you feel could result in a claim

The best guideline to follow for determination of whether a circumstance is reportable is that of common sense, sustained by the ever present awareness of the possibility of a claim. The standard practice should be that when in doubt, report.

AUTHORIZATION FOR RELEASE OF INFORMATION

The undersigned hereby authorizes the release of information as specified below to:

University of Florida J. Hillis Miller Health Center Self-Insurance Program, hereafter referred to as "Program."

The undersigned hereby authorizes his/her present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Program, upon its request, information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney or the Program may have a bearing upon his/her professional liability risk factors.

The undersigned also authorizes all medical associations, medical societies and managed care organizations in which he/she is or has been a member, all hospitals in which he/she now holds or has held staff privileges, the state board of medical examiners for the state in which he/she has practiced, the state department of public health for the state in which he/she has practiced or resided, motor vehicle departments, and any and all physicians having information regarding the undersigned, to release to the Program, upon its request, any information any such person or entity may have which, in the judgment of any such person or entity, has a bearing upon his/her professional liability risk factors.

_____

Provider Signature

Print Provider Name: _____

Date: _____

University of Florida J. Hillis Miller Health Center Self-Insurance Program (SIP)

PROFESSIONAL LIABILITY QUESTIONNAIRE

COVERAGE RESTRICTION & INFORMATION

Medical malpractice liability protection provided by the above named SIP is restricted to incidents and claims arising out of patient care rendered within the scope and course of your employment with the University of Florida.

Private physicians/providers appointed by the University of Florida Board of Trustees (UFBOT) to supervise, educate, and train UFBOT fellows, residents, and/or students have a limited personal immunity as set forth in Section 768.28(9), Florida Statutes. The limited personal immunity of Section 768.28(9), Florida Statutes, protects private physicians/ providers with UFBOT appointments for their negligence in supervising, educating, or training UFBOT fellows, residents, and/or students, and from vicarious liability arising from alleged negligent acts or omissions of UFBOT fellows, residents, and/or students. The exclusive remedy for alleged negligent acts or omissions of UFBOT fellows, residents, and/or students is an action against UFBOT.

The UFBOT appointment does NOT trigger the limited liability of Section 768.28(9), Florida Statutes, for patient care personally provided by appointed private physicians/providers. A private physician/provider is solely responsible for the care and treatment provided and must individually satisfy Florida professional financial responsibility requirements applicable to physicians.

For questions regarding UFBOT medical malpractice liability protection, please call (352) 273-7006, or (844) MY FL SIP, or visit our website at www.myflsip.org.

PROVIDER REPRESENTATIONS

I hereby declare that the statements and responses I have provided in this questionnaire are, to the best of my knowledge and recollection, complete and correct and that I have not deliberately suppressed or misstated any material facts. If any material change occurs during the term of my employment, I agree to notify the Underwriting Division of the Self-Insurance Program.

Further, I have read and agree to abide by the **Incident Reporting Requirements**.

_____
Provider Signature

Print Provider Name: _____

Date: _____

PROVIDER: Please attach a copy of your C.V., to include medical education, additional training, practice history, and board certifications. Explain all gaps in history greater than 3 months.

EMPLOYER REPRESENTATIONS: Dean of College or Director of Service

I hereby declare that the statements and responses the provider has provided in this questionnaire identifying the practice locations, patient care categories, and FTEs for his/her employment activities are correct. I further represent that if any material change occurs during the term covered by this application, I will notify the Underwriting Division of the Self-Insurance Program.

_____
Dean/Chair/Director Signature (or Appointed Designee)

Print Dean/Department Chair/Director Name: _____

Title: _____

Date: _____

Please scan and e-mail completed questionnaire and all attachments (CV, Authorization and Release of Information, and underwriting explanations) to ufisosip@mail.ufl.edu, or fax documents to (352) 273-5424.

UNDERWRITING FORM - CLAIM SUPPLEMENT

Provider Name: _____

If you answered YES to question 7 and/or 8 under the Underwriting Information section of this questionnaire, please complete a Claim Supplement for each claim, suit, and judgement against you. If N/A , please initial here _____.

Patient (or Plaintiff): _____ Date of Incident: _____

Date you became aware of this potential or actual malpractice claim? _____

How did you become aware of this claim?

Where did the event occur (facility, city and state)?

Provide a summary of the allegations or potential allegations.

Provide a summary of the alleged or potentially alleged injuries/damages.

Provide a summary of your involvement in the patient's treatment.

If the claim has been resolved, provide the date the case was settled and the amount of the settlement that was attributed to the care you provided.

If the claim has not been resolved, provide current status.

Defense Attorney (name/address):

Insurer (name/address):

Attach an additional sheet if you need more space or wish to provide additional information.

UNDERWRITING FORM - INSURANCE HISTORY

If N/A, please initial here _____

Provider Name: _____

List all previous and/or current medical malpractice insurance carriers.

Carrier: _____

Policy Number: _____ Policy Period: _____

Coverage Type: ☐ Claims-made ☐ Occurrence

Carrier: _____

Policy Number: _____ Policy Period: _____

Coverage Type: ☐ Claims-made ☐ Occurrence

Carrier: _____

Policy Number: _____ Policy Period: _____

Coverage Type: ☐ Claims-made ☐ Occurrence

Carrier: _____

Policy Number: _____ Policy Period: _____

Coverage Type: ☐ Claims-made ☐ Occurrence

Carrier: _____

Policy Number: _____ Policy Period: _____

Coverage Type: ☐ Claims-made ☐ Occurrence