

QUESTIONNAIRE NURSE MIDWIFE

Pages 1 through 3 to be completed by Nurse Midwife.

1. Your full name _____
Date of birth _____ Social Security Number _____
State Registered Nurse License Number _____ State _____
2. School attended _____ Date completed _____
3. Are you certified by the American College of Nurse Midwives? Yes _____ No _____
If yes, indicate certificate number _____ Expiration date _____
4. Employer's name _____
Employer's address _____

Employer's telephone number () _____
5. Name of supervising physician(s) _____

6. Are you applying for or do you have hospital privileges?
Yes _____ No _____ If yes, please list names of hospitals and extent of privileges granted.

7. Do you provide any direct patient treatment (not limited to obstetrical care) during delivery (including the immediate labor, puerperium and/or neonatal period) in any place other than a licensed acute care hospital?
Yes _____ No _____ If yes, please explain.

8. Please indicate previous employment as a Nurse Midwife.
(Give employer's name and address and dates of employment.)

9. Number of hours per week worked _____
10. Desired effective date _____
11. Present insurance carrier, policy number and expiration date _____

Medical and Insurance History

If you answer "yes" to any of the following questions, please provide a written narrative and pertinent documentation.

	YES	NO
1. INSURANCE		
Has any liability insurer ever cancelled, declined or modified coverage (e.g., reduced limits, assigned a deductible, restricted coverage, surcharged rates) or refused renewal of your insurance?	_____	_____
2. GOVERNMENT ACTION		
a. Has any governmental agency ever investigated you or suspended, revoked or taken any other action against your License or your Certificate?	_____	_____
b. Have you ever been charged with, or convicted of, a felony?	_____	_____
3. HOSPITALS		
a. Have your hospital privileges ever been restricted, suspended, revoked or declined, or has any hospital notified you of its intent to pursue such action?	_____	_____
b. Have you ever been under punitive or disciplinary observation, preceptorship or sponsorship in a hospital, or has any hospital notified you of its intent to pursue such action?	_____	_____
c. Have you ever voluntarily agreed to a modification of hospital privileges?	_____	_____
4. PROFESSIONAL SOCIETIES		
a. Has any health care provider or patient ever filed a complaint against you with your professional association?	_____	_____
b. Have you ever been subject to medical or professional society disciplinary proceedings or review?	_____	_____
c. Have you ever failed a certification examination?	_____	_____
5. HEALTH		
a. Have you ever been treated for alcoholism, narcotics addiction or mental illness?	_____	_____
b. Do you have any health problem, illness or physical defect that does impair or could tend to impair your ability to practice your specialty?	_____	_____
6. OTHER PROFESSIONAL CONDUCT		
Have you ever been subject to disciplinary proceedings or to a review affecting your participation with a foundation, HMO, PPO or IPA, or have you ever been notified of an intent to pursue such action?	_____	_____
7. CLAIMS		
Have you ever been notified of your involvement in a malpractice claim, suit or incident, either directly or indirectly?	_____	_____
If yes, you must complete a Claims Information form.		

8. OTHER INFORMATION

Please disclose any information material to the risk which has not otherwise been addressed in the application (attach additional sheets of paper if necessary).

I authorize release and exchange of information between my past and present professional association/society and their insurance consultants, any hospital where I presently hold or previously held staff privileges, prior insurance carriers, and NORCAL Mutual Insurance Company involving past and future underwriting and claims matters.

I hereby represent and warrant the truth of my statements and reasons mentioned herein, and that I have not withheld any information which is reasonably likely to influence the judgment of the company.

I understand that the purpose of this application is to assist NORCAL Mutual Insurance Company in determining the increased risk my practice presents to a NORCAL insured physician or entity. I further understand that through this application, I am not eligible for and will not receive individual professional liability insurance from NORCAL Mutual Insurance Company.

Signature _____ Date _____

.Reverse side to be completed by supervising physician(s)

Pages 4 and 5 to be completed by Supervising Physician(s).

1. Name _____

Address _____

Telephone Number () _____

2. Will Nurse Midwife practice solely at the above address?

Yes _____ No _____ If no, please explain.

3. What percentage of patients seen by Nurse Midwife will be seen by you as a matter of routine? _____%

4. How many deliveries do you perform on a monthly basis? _____

a. How many deliveries are performed by Nurse Midwife on a monthly basis? _____

5. What is your daily patient volume? _____

a. What is Nurse Midwife's daily patient volume? _____

6. What percentage of patients to be delivered by Nurse Midwife is seen by you:

a. In the first trimester? _____%

b. In the second trimester? _____%

c. In the third trimester? _____%

7. How often will charts of patients seen by Nurse Midwife be reviewed by you? _____

8. Does Nurse Midwife ever take call on your behalf or on behalf of a physician in your call rotation?

Yes _____ No _____ If yes, please explain in detail under what circumstances this occurs.

9. OTHER INFORMATION

Please disclose any information material to the risk which has not otherwise been addressed in the application (attach additional sheets of paper if necessary).

NOTE: The following material must be submitted with this application.

1. Nurse Midwife Certificate issued by the State Board of Registered Nurses;
2. State Registered Nurse License; and
3. Copy of the protocol used by the Nurse Midwife in your practice. The protocol must include the following information with regard to your supervisory relationship to the Nurse Midwife:
 - a. Scope of nurse-midwifery practice
 - b. Responsibility of each to the other
 - c. Communication arrangements
 - d. Arrangements for alternate consultation when you are unavailable
 - e. Arrangements for a hospital referral and an alternate supervising physician accessible to the Nurse Midwife's area of practice.

I hereby represent and warrant the truth of my statements and reasons mentioned herein, and that I have not withheld any information which is reasonably likely to influence the judgment of the company.

Signature _____ Date _____