

ALLIED MEDICAL PSYCIATRIST SUPPLEMENTAL APPLICATION
SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION:

1. Name of Clinic/Center: _____

2. List the professional societies of which you are a member: _____

3. License Number(s) and State(s): _____

Are you board-certified in Psychiatry? No Yes

If "No," are you eligible? No Yes

4. Do you perform electro-convulsive therapy for the center named above (ECT)? No Yes

a. Where is this procedure performed? _____

b. Is Anesthesia always administered in a licensed Medical facility? No Yes

c. Who administers Anesthesia? Anesthesiologist CRNA Other: (explain) _____

5. Medical School Attended: _____ Country: _____

Year Graduated: _____ Degree: _____

6. Has any insurance company ever declined, failed to renew, conditionally renewed or No Yes cancelled a Professional Liability Policy for you?

If "Yes," please list company, date, and reason for the action by the company:

7. Have you ever been:

a. The subject of an investigatory or disciplinary proceeding or reprimand? No Yes

b. Convicted for an act committed in violation of any law or ordinance other than No Yes traffic offenses?

c. Treated for alcoholism or drug addiction? No Yes

8. a. Have you ever had a malpractice claim or suit filed against you? No Yes

If "Yes," how many? _____

b. Do you know of any incident that may result in a claim against you? No Yes

If "Yes," for each claim, suit, or incident, complete a separate claim activity form.