Physicians Insurance
A MUTUAL COMPANY

Volunteer and Retired Providers (VRP) Program
Claims-Made Professional Liability Insurance Application

Electronic application available at wahealthcareaccessalliance.org/volunteers

You may fill out this application electronically **or** by hand. Please answer **all** questions, sign and return this application to:

By hand
Washington Healthcare Access Alliance, VRP Program
PO Box 7242
Tacoma, Washington 98417
Fax: (206) 260-8859

Electronically
vrp@wahealthcareaccessalliance.org

Contact us with any questions at: (267) 713-9422 or by email at vrp@wahealthcareaccessalliance.org

Applicant Demographics

Applicant Name		☐ WA State ☐ Out of State
Professional Designation		
Date of Birth		
Physical Address		
City	State	Zip Code
Email	Phone	

Practice and Rating Information

Date volunteer service begins (mm/dd/yyyy)
Name of clinic that you will be volunteering **(must be a VRP approved site)**
Speciality that you will practice

History

Washington State Professional License Number	
Board Certification Specialty	Month and year issued

Professional Profile Questions

1. Have any complaints ever been filed against you with a governmental agency, medical or professional society, or other medical entity? ☐ Yes ☐ No
2. Have you ever been subject to a governmental agency, medical or professional society, or other medical entity's disciplinary proceedings or reviews, or have you ever been notified of intent to pursue such action? ☐ Yes ☐ No
3. If "Yes," did the proceedings or review result in reprimand, censure, sanction, or modification or your practice, either voluntary or involuntary, or are you currently the subject of an administrative proceeding or review by such agency or society? ☐ Yes ☐ No
4. Have you ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐ Yes ☐ No
5. Has any professional liability insurance carrier ever declined, cancelled, refused renewal, or issued coverage on special terms (premium surcharge, deductible, etc.), or have you ever been notified of impending action of this nature? ☐ Yes ☐ No
6. Have you ever been diagnosed with, been treated for, or are currently being treated for alcoholism and/or chemical dependency? ☐ Yes ☐ No
7. Has any claim or suit for alleged malpractice ever been brought against you or your professional corporation? ☐ Yes ☐ No

If you answer 'yes' to any questions above, please provide full details for **all** claims even if they have been closed for no payment. Attach a separate sheet if necessary.

Date of Incident	Patient Name
Amount Paid	
Allegations	
For any negative responses, please explain:	

If filling out this form electronically, please sign the following page by hand:

1. Will you receive any compensation for your volunteer services? ☐ Yes ☐ No
2. Are you a student? ☐ Yes ☐ No
3. Is your volunteer service in Washington state at a VRP approved site? ☐ Yes ☐ No
4. I understand that I will only perform non-invasive care as defined by:
   Non-invasive care includes the administration of injections, suturing of minor lacerations, and the incision of boils and superficial abscesses. Obstetric care and procedures coded as surgery are not covered under non-invasive medical care. Non-invasive dental care includes diagnosis, oral hygiene, restoration, and extraction. Orthodontia and surgical treatments are not covered by VRP malpractice insurance.

   Please Initial: _____
5. I understand that my enrollment in the VRP Program in contingent on my completion of a short annual survey.

   Please Initial: _____

Authorization and Release (please read carefully)

I acknowledge that as a condition precedent to acceptance of this application and any future renewal thereof, an inquiry and investigation of my professional background, qualifications and competence, including such other underwriting or claim matters as are deemed relevant, may be conducted by Physicians Insurance or its duly authorized representatives. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, their insurance consultants or agents, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any of my attending or treating physicians, the Washington Physicians Health Program, any prior insurance carriers, prior employers or professional associates and Physicians Insurance or its duly authorized representatives. I hereby release and discharge the providers of information, Physicians Insurance, its duly authorized representatives and the members or consultants of any established peer review committees from any and all legal liabilities which might otherwise be incurred as a result of any communications, reports, disclosures and recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by Physicians Insurance or its duly authorized representatives. I agree to notify Physicians Insurance immediately, in writing, if there are any changes from which I have described in this application, including changes in my practice, in my partners or associates, medical license, professional office premises, practice locations, medical procedures or administrative responsibilities and hospital privileges. I understand that Physicians Insurance does not cover any liability of another person or organization with whom I assume an oral or written contract or agreement.

Authorized Signature Required Date

A photocopy of this authorization shall be considered as effective and valid as the original. Washington State law requires us to inform you of the following:

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Please return this form to the address listed on page one.

Washington Healthcare Access Alliance is here to support your work as a healthcare volunteer. Please let us know how we can help at vrp@wahealthcareaccessalliance.org.

Thank you for your interest in volunteering!