

# NASI Per Diem Malpractice

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Dear Anesthesiologist,

We appreciate your interest in NASI's Per Diem Malpractice Insurance. This service is for those providers who need a supplemental policy for working an assignment outside of their regular employment practice. Established in 1998, our policy is a mature A+ rated claims-made policy with built in tail coverage. Policy limits will be tailored to meet specific state and hospital requirements.

Please return these completed forms to the credentialing office listed at the bottom of this letter. Please make sure to provide all the pertinent information on the facility in which you will be working. Our credentialing department will process this application and an approval can be made in approximately 36 hours. Once the hospital verification and references are confirmed, you will be ready to request coverage for the days you will be working.

Fees will include an annual credentialing fee of \$150.00 and a coverage fee of \$175.00 per day worked. Coverage must be requested and paid for in advance. Please keep in mind that fees are non-refundable. To start this process, you may submit a check payable to Nationwide Anesthesia Services or use a Visa or MasterCard to make payment. Call 800-500-2634 or 800-630-3532 for all credit card transactions.

Please contact us with any questions or concerns. We thank you for your interest in NASI Per Diem insurance and look forward to working with you.

Best Regards,

***The NASI Credentialing Team***

***Linda Lindsey***

***800-500-2634***

***Linda.Lindsey@nasinc.net***

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**Please Complete Application  
and Return to NASI Credentialing Team:  
P.O. Box 992  
Sandersville, GA 31082  
Fax: 800-210-5545  
Questions Call: 800-500-2634 or 800-630-3532  
Email: [linda.lindsey@nasinc.net](mailto:linda.lindsey@nasinc.net)**

# NASI Per Diem Malpractice

## ANESTHESIOLOGIST PER DIEM PROFESSIONAL LIABILITY APPLICATION

### Applicant's Instructions

1. Answer all questions. If the answer requires detail, please attach a separate sheet.
2. Submit all required copies per Section VI.
3. Application must be signed and dated by owner.

Date of Application \_\_\_\_\_

**For a 1 year Renewal Process Only**, Applicant please complete the box below. This will allow 1 more year of credentialing from the original date of the application if approved by NASI Per Diem Malpractice. **DO NOT COMPLETE THIS BOX IF THIS IS YOUR INITIAL APPLICATION**

This renewal process is not valid unless you have had an approved NASI Per Diem Malpractice application for 1 year or more with no changes on this application necessary

\_\_\_\_\_ I certify that all of the information provided by me on this application (pages 1-5 ) is still current and valid as of:

Initials \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ I certify there have been **NO** judgments or settlements made against me in professional liability cases, or have claims pending that I am aware of:

Initials \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### I. PERSONAL INFORMATION:

Full Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

County of Residence \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Pager \_\_\_\_\_ E-mail \_\_\_\_\_

Date of Birth \_\_\_\_\_ Maiden / Former Name \_\_\_\_\_

Social Security No. \_\_\_\_\_ U.S. Citizen: Yes ☐ No ☐

Place of Birth: City \_\_\_\_\_ State \_\_\_\_\_ Country \_\_\_\_\_

If Incorporated: Business Name \_\_\_\_\_ Tax ID No. \_\_\_\_\_

Address: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Have you ever used a per diem malpractice insurance before? Yes ☐ No ☐

If yes, through who \_\_\_\_\_

Date used \_\_\_\_\_

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Initials

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**II. EDUCATION AND LICENSURE:**

Medical School \_\_\_\_\_ Year Completion \_\_\_\_\_ Degree \_\_\_\_\_

Residency \_\_\_\_\_ Year Completion \_\_\_\_\_ Degree \_\_\_\_\_

Other Education \_\_\_\_\_ Year Completion \_\_\_\_\_ Degree \_\_\_\_\_

High School \_\_\_\_\_ Year Completion \_\_\_\_\_ Degree \_\_\_\_\_

Board Certification? \_\_\_\_\_ Certification No. \_\_\_\_\_ Exp. Date \_\_\_\_\_

States Licensed \_\_\_\_\_

State of Original Licensure \_\_\_\_\_ Licenses Pending \_\_\_\_\_

Current Malpractice Carrier \_\_\_\_\_ Policy Limits \_\_\_\_\_

Are You Certified in BLS? Yes ☐ No ☐ ACLS? Yes ☐ No ☐ PALS? Yes ☐ No ☐ NALS? Yes ☐ No ☐

**III. TYPES OF CASES COMFORTABLE WITH:**

☐ Ortho ☐ Neuro ☐ Hearts ☐ Major Vascular ☐ Thoracic ☐ Uro ☐ OB ☐ GYN  
☐ Transplants ☐ Eyes ☐ Burns ☐ Geriatrics ☐ Trauma ☐ ENT ☐ Abortions ☐ Peds

Comments: \_\_\_\_\_

**IV. SKILLS PROFICIENT WITH:**

☐ Epidurals ☐ Spinals ☐ Bier ☐ Axillary ☐ A-Lines ☐ C-Lines ☐ Swan Ganz

Other Skills or Comments: \_\_\_\_\_

**V. IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, PLEASE PROVIDE COMPLETE DETAILS ON A SEPARATE SHEET:**

Do you have any illness, disease, mental or physical disability, or any other physical condition(s) which may limit or hinder your performance in the position for which you are applying? ☐ Yes ☐ No

Do you have any communicable diseases? ☐ Yes ☐ No

Have you ever received treatment or are you currently receiving treatment for substance abuse, alcohol abuse, or nerves? ☐ Yes ☐ No

Have you ever been convicted of a felony or crime other than a traffic violation? ☐ Yes ☐ No

Have your privileges at any healthcare facility ever been voluntarily or involuntarily relinquished, denied, suspended, diminished, revoked, or not renewed for any reason? ☐ Yes ☐ No

Have you ever been the subject of disciplinary proceedings at any healthcare facility? ☐ Yes ☐ No

Has your medical license in any state ever been voluntarily or involuntarily relinquished, suspended, terminated, restricted, or is currently being challenged? ☐ Yes ☐ No

Have you ever been the subject of disciplinary proceedings by any state licensure board? ☐ Yes ☐ No

Have you ever been suspended, terminated, sanctioned or otherwise restricted from participating in any private, public, federal, or state health insurance program (e.g., Medicare, Medicaid, Blue Shield)? ☐ Yes ☐ No

Have judgments or settlements been made against you in professional liability cases, or are claims pending?  
☐ Yes ☐ No



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Initials

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**VI. PLEASE INCLUDE CLEAR COPIES OF THE FOLLOWING WITH COMPLETED APPLICATION:**

- ☐ Completed Application
- ☐ Drivers License
- ☐ Social Security Card
- ☐ Signed Applicant's Statement of Consent and Release Form
- ☐ Typed Resume or Curriculum Vitae
- ☐ List of last three (3) places of employment, with complete addresses, phone numbers and contact names
- ☐ Copy of all State Licenses, DEA Certificate
- ☐ Copy of ACLS, BLS, PALS cards
- ☐ Copy of all Certificates from Medical School, Internship, Residency and Board Certification
- ☐ Four (4) completed Reference Inquiry Forms completed by MD's included below (new references will be required every two years)

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**VII. APPLICANT'S STATEMENT OF CONSENT AND RELEASE:**

The facts set forth in this application are true and complete. False statements on this application shall be considered sufficient cause for termination of insurance. NASI Per Diem Malpractice and its representatives are hereby authorized to make any investigations of my personal and professional history through any agency or bureau necessary, including but not limited to, criminal background and criminal reports. NASI Per Diem Malpractice is also authorized to investigate my ability, employment records or character through inquiries to the individuals and/or employers mentioned in this application.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

**DO NOT COMPLETE THIS BOX IF THIS IS YOUR INITIAL APPLICATION**

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Initials

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## NASI Per Diem Malpractice

### CLINICAL SKILLS CHECKLIST

I am proficient in the techniques and procedures indicated:

#### GENERAL ANESTHESIA AND ANALGESIA:

- ☐ Preoperative Evaluation and Meds
- ☐ Intravenous Agents
- ☐ Inhalation Agents
- ☐ Intramuscular Agents
- ☐ Other (Describe): \_\_\_\_\_

#### REGIONAL ANESTHESIA:

- ☐ Topical
- ☐ Infiltration
- ☐ Spinal
- ☐ Epidural & Caudal
- ☐ Intravenous
- ☐ Upper Extremity Blocks
- ☐ Lower Extremity Blocks
- ☐ Field Blocks
- ☐ Other Peripheral Blocks
- ☐ Other (Describe): \_\_\_\_\_

#### DIAGNOSTIC & THERAPEUTIC BLOCKS:

- ☐ Sympathetic Blocks
- ☐ Epidural
- ☐ Spinal – Differential
- ☐ Steroid, Alcohol & Drug Phenol Blocks
- ☐ Other (Describe): \_\_\_\_\_

#### SPECIALTIES OR SPECIFIC SKILLS:

- ☐ Open Heart
- ☐ Peds
- ☐ OB
- ☐ Pain Management

#### PROCEDURES:

- ☐ Intravenous Catheter Placement

#### Intravenous Administration of:

- ☐ Fluids
- ☐ Blood
- ☐ Plasma
- ☐ Plasma Expanders
- ☐ Muscle Relaxants
- ☐ Vasoactive Drugs
- ☐ Cardiac Drugs
- ☐ Other (Describe): \_\_\_\_\_
- ☐ Placement of CVP Lines
- ☐ Placement of Arterial Lines
- ☐ Placement of Right Heart & Pulmonary Lines
- ☐ Mechanical Ventilation
- ☐ Resuscitation Techniques & Therapy
- ☐ Cardiopulmonary Bypass Techniques
- ☐ Autotransfusion Techniques
- ☐ Hypotensive & Hypertensive Techniques
- ☐ Hypothermia
- ☐ Other (Describe): \_\_\_\_\_

#### CERTIFICATIONS:

- ☐ BLS ☐ PALS
- ☐ ACLS ☐ NALS
- ☐ Other (Describe): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

# NASI Per Diem Malpractice

## APPLICANT'S STATEMENT OF CONSENT AND RELEASE

I hereby authorize NASI Per Diem Solutions and its representatives to consult any person or organization and to inspect any materials having or containing information which may have any bearing on my professional, ethical, and moral qualifications, including my personal character and professional competence. I hereby authorize NASI Per Diem Malpractice background histories as NASI Per Diem Malpractice deems appropriate. I hereby appoint NASI Per Diem Malpractice my attorney in fact to request any such criminal, credit, professional, and personal reports, at any time, without the need to seek further authorization from me. I hereby agree that this authorization and appointment shall be valid until revoked by me in a written revocation delivered to NASI Per Diem Malpractice. I hereby release from liability NASI Per Diem Malpractice and its representatives for all acts performed in connection with evaluating my application for malpractice per diem insurance. I hereby release from liability all persons and organizations who furnish information concerning my professional competence, ethics, character, and other qualifications, and consent to the release of such information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

**NOTE TO APPLICANT:** *You should provide a signed copy of this Statement of Consent and Release to each reference who will be completing an inquiry/evaluation form or letter of reference on your behalf. A signed copy of this Statement should also be provided to NASI Per Diem Malpractice with your other application materials.*

# NASI Per Diem Malpractice

## Per Diem Facility Practice Questionnaire

Per Diem Applicant Name: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Facility mailing address: \_\_\_\_\_

Practice name & address, if different from Facility: \_\_\_\_\_

Primary Contact person: \_\_\_\_\_ Phone: \_\_\_\_\_

Title: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

Type of Facility: ☒ Hospital ☐ Surgery Center ☐ Office Based\*

Type of Accreditation: ☐ JCAHO \_\_\_\_\_ Date of Accreditation \_\_\_\_\_  
☐ AAAASF \_\_\_\_\_ Date of Accreditation \_\_\_\_\_  
☒ AAAHC \_\_\_\_\_ Date of Accreditation \_\_\_\_\_  
☐ Other \_\_\_\_\_ Date of Accreditation \_\_\_\_\_

\*Non accredited office based anesthesia will need to furnish a current copy of malpractice from either: the facility, the surgeon or the anesthesiologist. Also, a copy of the facility sedation certificate, if required by state.

Provider Malpractice Limits Required by Hospital/Facility: \_\_\_\_\_

Limits Verified by Facility Representative Name: \_\_\_\_\_

Title: \_\_\_\_\_ Dept: \_\_\_\_\_ Date: \_\_\_\_\_

### Credentialing:

Contact person: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Fax: \_\_\_\_\_

Requirements ☐ ACLS ☐ BLS ☐ PALS ☐ NALS

Type of cases required \_\_\_\_\_

Number of cases performed per year \_\_\_\_\_

Practice Description \_\_\_\_\_

Name of Chief Anesthesiologist \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Name of Chief CRNA \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

# of Anesthesiologists \_\_\_\_\_ # of CRNA's \_\_\_\_\_ # of OR's \_\_\_\_\_ # of Cystos \_\_\_\_\_ # of OB Suites \_\_\_\_\_



# NASI Per Diem Malpractice

## REFERENCE INQUIRY FORM

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**NASI Per Diem Malpractice**  
**P.O. Box 992**  
**Sandersville, GA 31082**  
**Fax (800) 210-5545**  
**Email: Linda.Lindsey@nasinc.net**

Thank you in advance for your response.

**Please note: This reference form cannot be accepted without a valid email and phone number for the person providing the reference**

Candidate Name: \_\_\_\_\_

Reference Name: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Office: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Hospital/Group: \_\_\_\_\_

Address: \_\_\_\_\_

Dates of Candidate's Employment: \_\_\_\_\_

Was Candidate Terminated? YES ☐ NO ☐ Would You Rehire? YES ☐ NO ☐

Were There Any Suspected Problems With Drugs, Alcohol, Nerves, Etc.? YES ☐ NO ☐

If Yes, Please Explain: \_\_\_\_\_

Please Evaluate The Candidate Below According To The Following Scale:

**A = ABOVE AVERAGE**

**B = AVERAGE**

**C = BELOW AVERAGE**

**D = UNACCEPTABLE**

\_\_\_\_\_ Adaptability To Work Situations

\_\_\_\_\_ Emotional Stability

\_\_\_\_\_ Personal Appearance

\_\_\_\_\_ Attendance And Punctuality

\_\_\_\_\_ Attitude

\_\_\_\_\_ Seeks Consultation When Necessary

\_\_\_\_\_ Technical Skills

\_\_\_\_\_ Overall Professional Competence

\_\_\_\_\_ Ability To Get Along With Physicians, Coworkers & Patients

\_\_\_\_\_ Cooperation

\_\_\_\_\_ Knowledge And Ability To Practice "Safe Anesthesia"

\_\_\_\_\_ Physical Assessment And Management Of "High Risk Patients"

Comments: \_\_\_\_\_

Reference Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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Comments: \_\_\_\_\_

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\_\_\_\_\_ Physical Assessment And Management Of "High Risk Patients"

Comments: \_\_\_\_\_

Reference Signature: \_\_\_\_\_ Date: \_\_\_\_\_