NASI Per Diem Malpractice

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. Limits will be tailored to meet specific state and hospital requirements and there is no deductible associated with claims.

Please return these completed forms, including all documents requested, 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 2-3 business days upon receipt of completed application and all documents required. Once the credentialing verification, facility 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, MasterCard or American Express 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
Amanda Griffin
877-844-2057
Amanda.Griffin@nasinc.net

Please Complete Application
and Return to NASI Credentialing Team:
P.O. Box 992
Sandersville, GA 31082
Fax: 800-210-5545
Questions Call: 877-844-2057
Email: amanda.griffin@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

DO NOT COMPLETE THIS BOX IF THIS IS YOUR INITIAL APPLICATION

_____ 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: _____

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-Employment to include beginning and ending dates-Month & Year
- ❑ 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
- ❑ Three (3) completed Reference Inquiry Forms completed by 2 MD's and 1 CRNA included below (new references will be required every 2 years)

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

_____ 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: _____

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) ☐ AAAHC _____ (Date of Accreditation)
☐ AAAASF _____ (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 _____