GREENHILL
INSURANCE SERVICES

Mailing Address:
1707 Post Oak, Suite 279
Houston, Texas 77056
WWW.GRNHLL.COM

Nurse's Professional Liability Application

General Information

1. Name _____
2. Address _____
   City _____ State _____ Zip _____
   Telephone Number: _____ Email: _____
   Requested Effective Date: _____ Date of Birth: _____
3. Licensed/Authorized as: ☐ Nurse ☐ Nurse Practitioner ☐ Other, Describe _____
4. How many years have you been practicing? _____
5. In which branch of your profession do you specialize? _____
6. License information for all states in which you practice: _____

_____

About Your Practice

7. Is your employer/ employment by or through a registry or temporary employment agency? ___ Yes ___ No
8. If your personal practice is incorporated, please provide entity name: _____
   List names of all partners or other professionals associated with the above listed corporation: _____
   _____
9. Provide the number of weekly hours in which coverage is being requested: _____
   Gross Annual Revenue: _____ Number of patients seen weekly: _____
   If practice is part-time/moonlighting, provide name and address of full time position along with weekly hours:
   _____
10. What percentage of your practice constitutes General Anesthesia procedures? _____%
    If practice includes Pain Management or injecting botox or ketamine, please provide percentage and description:
    _____
    _____
11. Does practice include assisting in surgical procedures? If so, please provide description: _____
    _____
12. Are you supervised by a Physician at each location where coverage is requested? ___ Yes ___ No

Practice Locations:

1. Principle Location in which coverage is requested:

   _____

   Please provide the number of weekly hours and type of facility: _____

2. Secondary Location in which coverage is requested:

   _____

   Please provide the number of weekly hours and type of facility: _____

3. If services are provided at more than 2 locations, please attach a schedule of additional locations with weekly hours and type of facility included.

Education and Training

1. Please provide the Name of Institution, state (country if outside the US), and Graduation Year for the following:
   Nursing School: _____
   APRN/CRNA School: _____
2. Are you a member of any professional associations? ___ Yes ___ No
   If yes, please list memberships: _____
3. Please attach a current curriculum vitae (CV).

Insurance History

List your prior Professional Liability insurance for each of the last five years, including current policy year:

Limits of Liability	Insurance Co.	Premium	Eff/Exp Date	Retroactive Date

Applicant and Claims History

1. Within the last ten years:
   a. Ever been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital, or professional organization? ___ Yes ___ No
   b. Ever been convicted for an act committed in violation of any law or ordinance other than a traffic offense? ___ Yes ___ No
   c. Ever been treated for alcoholism or drug addiction? ___ Yes ___ No
   d. Ever had any state professional license or license to prescribe/dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? ___ Yes ___ No
   e. Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? ___ Yes ___ No

If "Yes", please provide formal documents upon submission of application.

2. Within the last ten years:

a. Have any professional liability or sexual abuse claims been made against the applicant or a current or former employee? ___ Yes ___ No

b. Is the applicant or an employee aware of any fact, incident, act, event, circumstance, or occurrence that may result in a claim? ___ Yes ___ No

If “Yes”, please attach full details.

I am licensed or duly authorized in all states or jurisdictions where I provide Professional services, and I DO HEREBY WARRANT the truth of my answers to the above questions, and that I have not withheld any information which is calculated to influence the judgment of the company in considering this application for insurance.

Date

Signature of Applicant