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. 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 800-862-6470 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

Please Complete Application
and Return to NASI Credentialing Team:
P.O. Box 992
Sandersville, GA 31082
Toll Free Fax: 1-800-210-5545
Questions Call: (800) 500-2634 or (800) 862-6470
Email: linda.lindsey@nasinc.net

NASI Per Diem Malpractice

ANESTHESIOLOGIST PERDIEM PROFESIONAL LIABILTY 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 ________________________________

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 ____

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

NASI Per Diem Malpractice

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

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 license or certification 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

NASI Per Diem Malpractice

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 and BLS cards
- ☐ Copy of all Certificates from Medical School, Internship, Residency and Board Certifications
- ☐ Three (3) completed Reference Inquiry Forms (enclosed in application)

VII. REMUNERATION:

When using this Per Diem coverage will you be remunerated as:

- ☐ **Fee for Service/Contract Basis**
- ☐ **Paid Directly by the Facility**

VIII. 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.: ______________________________

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: ______________________________

APPLICANT'S STATEMENT OF CONSENT AND RELEASE

I hereby authorize NASI Per Diem Malpractice 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

REFERENCE INQUIRY FORM

NASI Per Diem Malpractice is a perdiem malpractice carrier for CRNA's and Anesthesiologist's. It is our policy that before an applicant can be considered for malpractice coverage they are screened thoroughly.
We have spoken with the candidate who has directed us to you for your personal and professional opinions.
Please take a moment to complete this evaluation form and return by mail, fax or email to:

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

Thank you in advance for your response.

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
______ Personal Appearance
______ Attitude
______ Technical Skills
______ Ability To Get Along With Physicians, Coworkers & Patients
______ Knowledge And Ability To Practice "Safe Anesthesia"
______ Physical Assessment And Management Of "High Risk Patients"
______ Emotional Stability
______ Attendance And Punctuality
______ Seeks Consultation When Necessary
______ Overall Professional Competence
______ Cooperation

Comments: ______________________________

____

Reference Signature: ______________________ **Date:** ______________

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_____ Attitude
_____ Technical Skills
_____ Ability To Get Along With Physicians, Coworkers & Patients
_____ Knowledge And Ability To Practice "Safe Anesthesia"
_____ Physical Assessment And Management Of "High Risk Patients"
_____ Emotional Stability
_____ Attendance And Punctuality
_____ Seeks Consultation When Necessary
_____ Overall Professional Competence
_____ Cooperation

Comments: ____

____

Reference Signature: ______________________________ **Date:** ____________________

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Hospital/Group: ______________________________

Address: ______________________________

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

If Yes, Please Explain: ______________________________

____

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_____ Physical Assessment And Management Of "High Risk Patients"
_____ Emotional Stability
_____ Attendance And Punctuality
_____ Seeks Consultation When Necessary
_____ Overall Professional Competence
_____ Cooperation

Comments: ______________________________

____

Reference Signature: ______________________ **Date:** ______________

NASI Per Diem Malpractice

Per Diem Facility Practice Questionnaire

Per Diem Applicant Name: ______________________________

Facility Name: ______________________________

Facility mailing address: ______________________________

____

Practice name & address, if different from Client: ______________________________

____

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)

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 ______