

## Letter Regarding Professional Liability Coverage

Dear Healthcare Professional:

While on assignment, professional liability coverage is an important component of your comprehensive benefits package. Professional liability coverage is a requirement to travel, and we offer coverage available with limits up to \$2 million to our Healthcare Professionals while on assignment with us. To activate this coverage, complete the enclosed application and return it to us in the enclosed envelope as soon as possible so as not to delay the start of your assignment.

Rx Pro Health is aware of how important professional liability is to both you and our facility clients. The insurance policy we provide is through Lexington Insurance, an AIG Company which is A+ rated, and includes Good Samaritan Act coverage and pays the cost for Licensing authority investigators. If a patient injures you, this policy also helps cover your medical expenses. We are proud to offer this excellent coverage.

**Please complete and return the enclosed application to receive this valuable benefit. We work directly with the insurer to process your application and activate your policy.**

**If you have any questions concerning this insurance program, please contact our Quality Services Team at 866-960-5336. Prepare yourself for an exciting and rewarding assignment!**

Sincerely,

Kim Windsor, RN DHA  
*Vice President, Clinical Services*  
AMN Healthcare, Inc.

## **IMPORTANT INFORMATION ABOUT YOUR PROFESSIONAL LIABILITY PROTECTION**

Rx Pro Health, an AMN Healthcare Company, is pleased to provide you with professional liability insurance coverage as part of your benefits package. It is important that you comply with the following to maximize your protection under this policy.

If you are involved in an incident in which there may be an allegation of negligence, an allegation of abuse or harassment, or a violation of rules or procedures, or if you are requested to give a statement, interview or deposition relating to an incident or lawsuit, it is essential that you notify your recruiter and pharmacy supervisor immediately. Your recruiter will put you in contact with a clinical liaison from AMN Services who will assist you in reporting the incident to your insurance company if applicable. A delay in reporting the matter could result in the insurance company's rejection of any claim that may result.

Reporting any involvement in a potential professional liability situation necessitates the collection of information. Before you report the incident, answer as many of the following questions as possible:

- What was the date and time of the incident or dispensing error?
- Who was the patient(s) involved?
- How did the incident occur? Please provide a description of the incident.
- Who was working with you at the time of the incident? (pharmacists, technicians, etc.)
- Did the incident result in injury?
- Have there been any threats of legal action? If so, by whom?

It is important to refrain from discussing the incident with anyone other than a representative of Rx Pro Health, AMN Healthcare, your insurance company, or Facility management unless specifically directed to do so by a Clinical Liaison or risk management representative at Rx Pro Health, AMN Healthcare or manager from the Facility.

As further protection, you may want to take advantage of some of the courses offered by [rxschool.com](http://rxschool.com) regarding risk management and prevention of medication errors. You may take advantage of this or other course offerings by calling [rxschool.com](http://rxschool.com) at 888-682-4415 or viewing the course catalog online at [www.rxschool.com](http://www.rxschool.com).

# Personal Professional Liability Application

First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Apartment #: \_\_\_\_\_  
City: \_\_\_\_\_ County: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Professional License #: \_\_\_\_\_

1. Please indicate your profession:

- |                                  |                                  |  |
|----------------------------------|----------------------------------|--|
| <input type="checkbox"/> RN      | <input type="checkbox"/> SLP     | <input type="checkbox"/> Pharmacist                            |
| <input type="checkbox"/> LPN/LVN | <input type="checkbox"/> OT/COTA | <input type="checkbox"/> Pharmacy Technician                   |
| <input type="checkbox"/> ST      | <input type="checkbox"/> PT      | <input type="checkbox"/> Other Allied Prof. (please indicate): |
| <input type="checkbox"/> NP      | <input type="checkbox"/> RT      | _____  |

2. Have you ever been the subject of a reprimand or disciplinary action or refused employment or admission to a professional society or had professional privileges suspended by any court or administrative agency or ever been the subject of any ethic investigation at local, state or national level?

Yes  No *If yes, please attach a separate sheet with full particulars.*

3. Has any professional liability/malpractice insurance ever been cancelled or non-renewed?

Yes  No NOTE: MISSOURI RESIDENTS DO NOT RESPOND

4. Has any malpractice suit ever been brought against you?

Yes  No *If yes, please attach a separate sheet with full particulars.*

5. Are you aware of any circumstances, which may result in a malpractice claim or suit being made or brought against you?

Yes  No *If yes, please attach separate sheet with full particulars.*

6. Please indicate all levels of license and/or certifications that you have held:

- |                                     |                             |                             |  |  |
|-------------------------------------|-----------------------------|-----------------------------|--|--|
| <input type="checkbox"/> LVN        | <input type="checkbox"/> RN | <input type="checkbox"/> PA | <input type="checkbox"/> Nurse Practitioner  | <input type="checkbox"/> Nurse Midwife |
| <input type="checkbox"/> Pharmacist |                             |                             | <input type="checkbox"/> Pharmacy Technician |  |

If you have selected Nurse Practitioner, please indicate your specialty below:

- |                                       |                                   |   |  |
|---------------------------------------|-----------------------------------|---|--|
| <input type="checkbox"/> Geriatric    | <input type="checkbox"/> Adult    | <input type="checkbox"/> Family Planning (GYN only) | <input type="checkbox"/> Psychiatric         |
| <input type="checkbox"/> Pediatric    | <input type="checkbox"/> Neonatal | <input type="checkbox"/> Family Practice            | <input type="checkbox"/> Acute Critical Care |
| <input type="checkbox"/> School Nurse | <input type="checkbox"/> OB-GYN   | <input type="checkbox"/> Acute Critical Care OB-GYN |  |

If you have graduated within the past year, please indicate from where and when:

Name of School \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

7. Are you a foreign-trained nurse who had midwifery courses as part of your training?

Yes  No

8. Do you currently have an individual self-insured professional liability policy?

Yes  No *If yes, please provide additional information below*

Name of Ins. carrier \_\_\_\_\_ Amount of coverage \_\_\_\_\_ Effective dates of coverage \_\_\_\_\_  
Policy Number \_\_\_\_\_

The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, he/she (undersigned) will immediately notify the company and insurance carrier of such changes, and the company and/or insurance carrier may withdraw or modify any outstanding authorization or agreement to bind the insurance.

**YOU MUST SIGN THE SECOND PAGE AND RETURN BOTH PAGES OF THIS APPLICATION IN ORDER TO OBTAIN COVERAGE.**



Signing of this application does not bind the company or insurance carrier to complete the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued, and it will be attached to and become a part of the policy. **Signing this application gives AMN Healthcare and the insurance carrier the right to make payments or settle any claims on your behalf without your approval.**

All written statements and materials furnished to the company and/or insurance carrier in conjunction with the application are hereby incorporated by reference into the application and made a part hereof.

**The earliest effective date for which a policy may be issued is the date this application is received in the insurance carrier's office.**

**Notice to Arkansas Applicants:** "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

**Notice to Colorado Applicants:** "It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance who knowingly provides incomplete or misleading facts, or information to a policyholder, or claimant for the purpose of defrauding, or attempting to defraud the policyholder, or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory authorities."

**Notice to District of Columbia Applicants:** "Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment, and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant."

**Notice to Florida Applicants:** "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony in the third degree."

**Notice to Kentucky Applicants:** "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime."

**Notice to Louisiana Applicants:** "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

**Notice to Maine Applicant:** "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits."

**Notice to New Jersey Applicants:** "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

**Notice to New Mexico Applicants:** "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties."

**Notice to New York Applicants:** "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

**Notice to Ohio Applicants:** "Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud."

**Notice to Oklahoma Applicants:** "Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony." (365:15-1-10, 36 3613.1).

**Notice to Pennsylvania Applicants:** "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

**Notice to Virginia Applicants:** "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."

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

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

**Fax to: (800) 236-5633**



# Supplemental Claim Form

If you answered **Yes** to the questions regarding claim or potential claims (questions 2, 3, 4 or 5), complete a **separate** Supplemental Claim Form for each actual or potential claim. Answer **each** question fully. *Please submit type-written.*

1. Applicant's Name: \_\_\_\_\_

2. Full Name of Claimant: \_\_\_\_\_

3. Date of Alleged Error: \_\_\_\_\_ Date Claim Was Made: \_\_\_\_\_

4. To what insurance company did you report this claim? \_\_\_\_\_

5. Present Status of Claim:  Open/Incident in Suit  Closed

6. If Closed:

(a) Total damages paid and outstanding (including deductible): \_\_\_\_\_

(b) Total defense costs paid: \_\_\_\_\_

(c) Date closed: \_\_\_\_\_

7. If Open/Incident in Suit:

(a) Claimant's settlement demand: \$ \_\_\_\_\_

(b) Defendant's offer for settlement: \$ \_\_\_\_\_

(c) Insurer's reserve: \$ \_\_\_\_\_

(d) Amount paid to date: \$ \_\_\_\_\_

8. Description of Claim or Incident. Please do not attach a copy of papers, instruct to refer to file or contact Company representative. Information must be provided to allow an evaluation of the claim or incident.

(a) Allegation upon which claimant bases claim: \_\_\_\_\_  
\_\_\_\_\_

(b) Description of case and events: \_\_\_\_\_  
\_\_\_\_\_

9. What steps have been taken to prevent a similar claim? \_\_\_\_\_  
\_\_\_\_\_

*I understand the information submitted herein becomes a part of the applicant's Insurance Application and is subject to the same representations and conditions.*

**Applicant signature and date required. Fax to: (800) 236-5633**

Signature of Applicant: \_\_\_\_\_

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

