LOUISIANA PATIENTS' COMPENSATION FUND

SELF INSURED HEALTHCARE PROFESSIONAL APPLICATION

DATES OF ENROLLMENT APPLYING FOR:_____**to**_____

I, _____, _____, am licensed
(**PRINT** First name, middle name and last name) (Prof. Degree)

to provide professional medical services as a (Specialty/designation)_____.

LICENSE NUMBER:_____ **DATE OF BIRTH** _____

Email Address:_____ _____

Do you work part time? _____ Number of hrs/week? _____ **Complete Form PCF12**

****Advanced Practice Nurse- list supervising physician:**_____

RENEWAL APPLICATIONS ONLY: Complete the first page only unless there are changes to your practice.
I that the appropriate security (proof of financial responsibility) is in place and current at the following institution: _____.

Circle any that apply to your practice : ☐Spa Services ☐Laser Hair Removal ☐Botox

☐ Facial Fillers ☐ Facial Chemical Peels ☐ Tatoo removals

INCLUSIONS:

Employed allied healthcare providers.

EXCLUSIONS:

*This does **not** include those who require a PCF surcharge,- MD's, NP's, PA's, CNS', CRNA's, etc.*

PCF RESERVES THE RIGHT TO DENY COVERAGE FOR THE FOLLOWING:

(1) Injury arising out of a criminal act, including but not limited to sexual abuse or molestation, fraud committed by the insured or any person for whom the insured is legally responsible, and battery.
(2) Third (3rd) party claims filed by an injured party that was not a patient of the health care provider.
(3) Services or treatment rendered as a licensed provider in states other than Louisiana.

Your attention is directed to LAC 37:III, Chapter 11, §§1101-1105, which sets forth the cost and reserve reporting requirements which you must satisfy within the time allotted therein. Please note §1105 which provides for the cancellation and termination of enrollment with the Patient's Compensation Fund for failure to comply with these reporting requirements.

I hereby certify that there have been no changes in any aspect addressed by this form since my last completed application to the LA PCF **especially in regards to questions number 10, 11 and 12**.

SIGNED: _____**DATE:** _____

1. Office Address (no P.O. Box):_____

   _____

   City _____ Parish_____

   State/Zip _____Telephone_____

2. Home Address _____

   _____

3. Professional degree from _____

   County _____ Degree_____ Year_____

4. Internships and Residencies (dates, services & locations):

   _____

   _____

5. Present Specialty _____ Sub-specialties _____

   Board Certified _____

6. Local professional society _____

7. Staff privileges at _____

8. Name of previous professional liability carrier _____

9. I am not employed by any physicians group, firm, hospital or corporation except as follows: (if no exception, so state)

   _____

   _____

10. Do you or your medical partnership or corporation with which you are professionally involved employ any of the following: Licensed Physician Assistants, Licensed Nurse Practitioners, CRNAs, Nurse Midwives, and/or Surgical Assistants or Pharmacists? **If yes, and you wish to provide coverage through your self insurance, please list their names and include the appropriate surcharge for each**.

    _____

11. List names of any partners (if applicable): _____

_____

12. Are you a stockholder in a professional medical corporation? **If yes, you must complete the corporation application (PCF9) from our website and return it with your payment.**
_____

Name of corporation/partnership/LLC/LLP/AMPC_____

_____

13. Please indicate answers to questions below. Fully explain any "yes" answer in space allowed.

		YES	NO
a.	Do you practice medicine outside of Louisiana?		
b.	Do you provide care at a Correctional Institute?		
c.	Has membership in any professional association or society ever been revoked?		
d.	Has any hospital suspended, restricted or refused you staff privileges?		
e.	Have you ever voluntarily surrendered or had a state license to practice medicine refused, suspended or revoked?		
f.	Have you ever voluntarily surrendered or had a narcotics license refused, suspended or revoked?		
g.	Have you ever been treated for alcoholism, narcotic addiction or mental illness?		
h.	Have you ever been convicted of a crime?		
i.	Have you ever had any chronic illness or physical defect?		
j.	Have you ever had any professional liability insurance refused, cancelled or non-renewed?		
k.	Do you work in any emergency room or industrial medical facility?		
l.	Do you own, operate or supervise the operation of any hospital or sanitarium?		
m.	Have any claims or suits been filed against you during the past 5 years as a result of professional services rendered?		
n.	Are you employed or contracted by a facility as a Medical Director?		

Details on "yes" answers (please identify by letter): _____

_____

14. Please indicate which of the following medical/surgical procedures you engage in:

	Accupunture		Gynecology		Open spinal procedures (non-diagnostic)
	Administer general anesthesia		Gynecology-surgery		Ophthalmology Surgery
	Anesthesiology		Hand Surgery		Oral Surgery
					Orthopedic Surgery w/spine
	Angiography		Hematology		Orthopedic Surgery-no spine
	Appendectomies		Hemorrhoidectomies		Orthopedic – Minor Surgery
	Assist in surgery		Hysterectomies		Otorhinolaryngology
	Cardiac catheterization		Intensive Care Medicine		Pathology
	Cardiac Surgery		Internal Medicine		Pediatrics

	Cardiovascular Diseases		Internal Medicine-surgery		Physiatry or Physical Medicine & Rehab
	Cardiovascular Surgery		Laser Procedures -explain		Plastic Surgery
	Cesarean sections		Major surgery in E.R.		Psychiatry
	D & Cs / Abortions		Needle Biopsies		Saddle blocks
	Dermabrasions		Neonatology		Spinal anesthetics/Epidural
	Dermatology		Nephrology		T & A's
	Electroshock therapy		Neurology		Telemedicine/Teleradiology
	Emergency Medicine		Neurosurgery		Thoracic Surgery
	Family Practice		Obstetrical deliveries		Traumatic Surgery
	Family Practice–surgery		Obstetrics		Tubal ligations
	Gastroenterology		Obstetrics/Gynecology		Urological Surgery
	General Practice		Occupational Medicine		Vascular Surgery
	General Practice-surgery		Office x-rays		Vasectomies
	General Surgery		Open reductions of fractures		Weight control (other than diet)

15. Do you perform x-ray or other radiation therapy? _____

If so, please list x-ray or Radium technicians employed by you: _____

_____

Signed: _____ Date: _____