

Benchmark

MANAGEMENT GROUP, INC.

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ALLIED MEDICAL PERFUSIONIST SUPPLEMENTAL APPLICATION

SECTION I: GENERAL INFORMATION (To be completed by all applicants):

1. Full name of Applicant: _____
2. Group Name: _____
3. Home Address: _____
4. City: _____ 5. State: _____ 6. Zip Code: _____
7. Phone Number: _____ 8. Fax Number: _____
9. Date of Birth: _____ 10. Social Security #: _____
11. **I am certified by American Board of Cardiovascular Perfusion:** Yes No
12. Please provide ABCP certificate # and date of certification: _____
13. Has certification ever lapsed? Yes No
14. Are you eligible for certification by ABCP: Yes No
If "yes", give date you expect to be certified: _____
15. Provide license numbers for each state in which you are licensed:

SECTION II: EDUCATION INFORMATION

Education (check all those you have completed):

1. College/University Name: _____
2. Degree earned & date: _____
3. Graduate School Name: _____ Degree earned & date: _____
4. **Perfusion School Name:** _____ **Date Graduated:** _____
5. Other (Specify): _____
6. List All Designations: _____
7. Professional societies and organizations to which you belong: _____

SECTION III: EMPLOYMENT INFORMATION

1. Group's Name and Address: _____
2. Address: _____
3. City: _____ 4. State: _____ 5. Zip Code: _____
6. Phone Number: _____ 7. Fax Number: _____
8. Full Time: Yes No 9. Part Time (Less than 75 cases per year): Yes No
10. Total caseload # in which you are involved: Adult #: _____ Pediatric #: _____
11. Years of adult experience: _____ 12. Years of pediatric experience: _____
13. Please list all hospitals or other facilities where you will perform perfusion services:

Name & Address Of Facility	Administrator's Name	Type of Facility	Procedures Performed	Hospital Caseload	Total # included

14. I provide or assist in (check all that apply):
- | | | |
|---|--|---|
| <input type="checkbox"/> Isolated Limb Perfusion | <input type="checkbox"/> Heart Transplantation | <input type="checkbox"/> Lung Transplantation |
| <input type="checkbox"/> Routine Adult Open Heart | <input type="checkbox"/> Routine Pediatric Open Heart | <input type="checkbox"/> Liver Transplantation |
| <input type="checkbox"/> Platelet Gel/Rich Plasma | <input type="checkbox"/> Electrophysiological Analysis | <input type="checkbox"/> Vein Harvesting |
| <input type="checkbox"/> ECMO | <input type="checkbox"/> LV/RV | <input type="checkbox"/> Surgical Assistance |
| | | 1 st Assist <input type="checkbox"/> 2 nd Assist <input type="checkbox"/> 3 rd Assist <input type="checkbox"/> |

15. Do you perform fill-in work for others? Yes No If "Yes", number of cases: _____

16. I use the following safety devices (check all that apply):
- | | | |
|---|---|---|
| <input type="checkbox"/> Arterial Line Filtration | <input type="checkbox"/> Centrifugal Pump | <input type="checkbox"/> Oxygen Saturation Monitoring |
| <input type="checkbox"/> In-Line PO2 monitoring | <input type="checkbox"/> Bubble Detector | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Level Sensing Device | <input type="checkbox"/> Closed Circuit Systems | <input type="checkbox"/> _____ |

17. Who owns the equipment? _____

18. Who maintains the equipment? _____

SECTION IV: COVERAGE REQUEST

1. Requested Limits of Liability: \$100,000/\$300,000
2. Requested Effective Date: _____ / _____ / _____
3. Requested Retroactive Date: _____ / _____ / _____

\$500,000/\$500,000

\$1,000,000/\$3,000,000

4. List your professional liability insurance for each of the **last five (5) years**. If none, state NONE.

Inception Date	Expiration Date	Name of Insurance Carrier	Policy Number	Premium	Limits of Liability

SECTION V: PRIOR EXPERIENCE

Yes No 1. Has there ever been a claim or suit, settled or pending, made against you for malpractice and/or peer review? **If "YES", a Supplemental Claim Information Form must be completed for each incident, claim or suit.**

Yes No 2. Do you have reason to believe that your past treatment of, or failure to treat a patient may result in a claim or suit against you or any perfusionist in practice with you? **If "YES", a Supplemental Claim Form must be completed for each incident, claim, or suit.**

Yes No 3. Has any claim or suit ever been brought against any perfusionist associated in practice with you as a result of alleged malpractice, error or mistake? **If "YES", a Supplemental Claim Form must be completed for each incident, claim or suit.**

Yes No 4. Have you ever appeared before the state-licensing agency for professional misconduct? **If "YES", please provide a copy of the board's findings.**

* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

* not applicable in all states

CLAIMS-MADE APPLICANTS ONLY:

I have requested my policy on a "Claims-Made" form and acknowledge that this policy will only respond to claims which are reported during the term of this policy. I also acknowledge that my "Claims-Made" policy will not provide insurance coverage for claims which occurred prior to the Prior Acts date of my policy.

I understand that should my "Claims-Made" policy with this insurance carrier ever be cancelled or non-renewed, or I decide to terminate it for any reason, and I desire to provide insurance protection for any claims which may have occurred during the term of the "Claims-Made" policy, but were not reported to the insurance company before the date of the policy termination, I will be required to purchase additional insurance coverage.

SIGNING THIS FORM DOES NOT BIND THE COMPANY OR THE UNDERWRITING MANAGER TO COMPLETE THIS INSURANCE.

NO INSURANCE SHALL BE GRANTED UNLESS ALL QUESTIONS ARE ANSWERED AND THE APPLICATION IS SIGNED AND DATED.

Signature

Date