Missouri Medical Malpractice Joint Underwriting Association

Post Office Box 85
Jefferson City, MO 65102-0085
Phone: 1-866-586-1693
Fax: 1-866-258-4892

Locum Tenens Physician, Surgeon, and Dentist Professional Liability Application

Prior approval of Locum Tenens coverage must be obtained from the Association. Application for coverage does not guarantee acceptance. Requests for coverage received after the locum period will not be accepted and coverage will not be provided.

THIS SECTION MUST BE COMPLETED BY THE CURRENT INSURED PHYSICIAN/SURGEON/DENTIST.

Name of Insured			
Address	City	State	Zip Code
Phone	Policy Number		
Specialty	Sub-Specialty		
State Reason for requesting Locum Tenens Coverage			
Were you regularly scheduled to work during the Locum Tenens Period?: ☐ Yes ☐ No			

Coverage is Requested for: (Please provide total number of days)	From Date:	To Date:

Insured Physician/Surgeon/Dentist Signature: **Date:**

THIS SECTION MUST BE COMPLETED BY THE LOCUM TENENS PHYSICIAN/SURGEON/DENTIST.

Name of Insured			
Address	City	State	Zip Code
Phone	Missouri License Number		
Specialty	Sub-Specialty		

Name of Medical School(s) Attended	Location	Degree	Date Graduated

Name of Hospital Where Residency Served	Location of Hospital Where Residency Served	
Specialty and/or Department	Start Date and End Date	Was Program Completed? ❑ Yes ❑ No

Missouri Medical Malpractice Joint Underwriting Association

Post Office Box 85
Jefferson City, MO 65102-0085
Phone: 1-866-586-1693
Fax: 1-866-258-4892

1. Do you practice as a locum tenens physician on a full-time basis? ❑ Yes ❑ No
2. Do you maintain a practice solely located in the State of Missouri? ❑ Yes ❑ No

   If no, please provide verification of insurance coverage applicable in states other than Missouri. The JUA policy will provide coverage only for services rendered within the state of Missouri.
3. Do you currently maintain individual professional liability in the State of Missouri? ❑ Yes ❑ No
4. Do you have active privileges at the hospitals you will cover during this locums period? ❑ Yes ❑ No
5. Are you certified by an approved specialty board in the specialty for which locums coverage is being provided? ❑ Yes ❑ No
6. Has any hospital ever denied, restricted, suspended, or revoked your privileges; have you ever voluntarily surrendered your privileges; or has probation or reprimand ever been invoked? ❑ Yes ❑ No
   If yes, please explain below.
7. Has your narcotics or medical/dental license ever been suspended, restricted, revoked, or voluntarily surrendered, or has probation or reprimand ever been invoked? ❑ Yes ❑ No
   If yes, please explain below.
8. Have you ever been evaluated or recommended for treatment for, diagnosed with, or treated for alcohol, narcotics or any other substance abuse sexual addition or mental health? ❑ Yes ❑ No

   If yes, please explain below, and answer the following question:

   Have you had a relapse following your initial treatment? ❑ Yes ❑ No
9. Have you ever been asked to participate in or have you volunteered to participate in an impaired physician/dental program? (If yes, please attach a copy of your recovery plan) ❑ Yes ❑ No
   If yes, please explain below.
10. Have you ever been denied a medical/dental license or been denied certification by a specialty board? ❑ Yes ❑ No

    If yes, please explain below.
11. Have you ever been accused of sexual misconduct of any kind? ❑ Yes ❑ No

    If yes, please explain below.
12. Has a patient or his representative ever filed a complaint or grievance against you with a hospital committee, state licensing or regulatory agency or other medical review committee? ❑ Yes ❑ No
    If yes, please explain below.
13. Other than a minor traffic offense, have you ever been indicted for, charged with, convicted of , pled guilty to, or entered into a plea agreement for a violation of any law or ordinance? ❑ Yes ❑ No
    If yes, please explain below.
14. In the past twelve months, have you had any injury, illness, or other event occur that may impair, lessen or diminish your physical or mental ability to practice medicine? ❑ Yes ❑ No
    If yes, please explain below.
15. Have you ever appeared before, been investigated by, or entered into any consent agreement with any formal hospital committee, state licensing Board, Board of Medical Examiners, or other medical review committee? ❑ Yes ❑ No
    If yes, please explain below.
16. Are you now, or have you ever been involved, directly or indirectly in a claim, potential claim, or a suit arising out of the rendering or failing to render professional services? ❑ Yes ❑ No

    If "Yes" A. Indicate number closed, dropped, dismissed _____

    B. Indicate number pending or open _____

    C. Total number of cases (A+B) _____

    If "Yes," Have all claim/suits indicted in"C" above been reported to your current or prior professional liability carrier? ❑ Yes ❑ No

Please attach additional sheets with dates and explanations.

Missouri Medical Malpractice Joint Underwriting Association

Post Office Box 85
Jefferson City, MO 65102-0085
Phone: 1-866-586-1693
Fax: 1-866-258-4892

Locum Tenens Physician/Surgeon Signature:	**Date:**

FOR COMPANY USE ONLY

❑Approved ❑ Declined Underwriter: _____ Date: _____