



**PATIENT LOAD QUESTIONNAIRE  
PROFESSIONAL LIABILITY POLICY**

**APPLICANT'S/INSURED'S NAME AND MAILING ADDRESS**

Name:			<b>Producer Name and Code</b> <i>(To be completed by Agent or Broker only)</i>					
Street:								
City:	State:	Zip Code:						

**IF MORE SPACE IS NEEDED TO ANSWER THE QUESTIONS ON THIS FORM, PLEASE ATTACH A SEPARATE SHEET DETAILING ALL INFORMATION REQUESTED.**

**PROFESSIONAL OFFICE LOCATIONS (please attach separate page for additional locations.)**

Loc. No.	Address (No. Street, City, State & Zip Code)	Posted Hours at Each Location						
		Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
1.								
2.								

**PRACTICE PATIENT LOAD AND HOURS (Based upon past 12 months practice.)**

*\*A patient "visit" is each time a patient is seen at a professional office, Hospital outpatient department, emergency room, clinic or other health care location.*

*\*For physicians entering practice within the past 12 months, estimate amount for the next 12 months.*

State (or District of Columbia)	Annual No. of Patient "Visits" (Excluding Hospital Inpatients)	Annual No. of Hospital Patients Seen (Includes Admissions, Procedures or Consultations)	Avg. Hours Per Week in Each State Listed
MD			
DC			

**PLEASE LIST ALL HOSPITALS, CLINICS AND ANY HEALTH ORGANIZATIONS WITH WHICH YOU ARE AFFILIATED**

State or DC	Active	Courtesy	Hospital/Clinic/Health Organizations (i.e. HMO, PPO) Please Attach Separate Page For Additional Facilities.
MD	<input type="checkbox"/>	<input type="checkbox"/>	
DC	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	

**INSURED'S STATEMENT**

I certify (and warrant where permitted by law to do so) that the information contained in this Application and any Supplements or additional written documents are complete and true. I understand that this Application is subject to acceptance by the Company and does not bind coverage, that where permitted by law, it will be made a part of any policy issued to me, and that any misrepresentation or omission of material facts will void the policy. I hereby authorize any hospital, health care provider, medical association or society, board of medical examiners, governmental agency, insurance carrier, attorney or any other person or entity having such information to release to the Company any claims or other information which in the judgment of the Company may have a bearing on my acceptability to the Company as a liability risk. I hereby release and agree to hold harmless, any releasing party, its agents, servants and employees, as well as the Company, its directors, officers, employees or agents, from any liability arising out of the release or use of the released information notwithstanding that there may be errors or omissions in such information.

\_\_\_\_\_ Date  
 \_\_\_\_\_ Applicant's/Insured's Signature