Membership #_____

South Carolina Medical Malpractice
PATIENTS' COMPENSATION FUND
PO Box 210738
Columbia, SC 29221-0738
(803) 896-5290 Fax (803) 896-5294

CERTIFICATE OF MEMBERSHIP FOR ALLIED HEALTHCARE WORKERS ASSESSABLE

General Information

Name _____ License Number _____

Work Address _____ Telephone _____

Home Address _____ Telephone _____

E-Mail Address _____ Fax _____ Date of Birth _____

Primary Insurance _____ Primary Policy # _____ Primary Policy Dates _____ Primary Limits _____

Primary Ins Premium _____ Specialty _____

Are you a U.S. Citizen _____ Yes _____ No. What is your current status: _____ *Please notify us of any changes immediately.*

Preceptor Information

Preceptor's Name _____ Preceptor's Membership #_____ Preceptor's Specialty _____

Name of practice/entity organization: _____

Check if you are a:

_____ Registered Nurse _____ Nurse Practitioner _____ Nurse Anesthetist _____ Nurse Midwife
_____ Pharmacist _____ Physician Assistant _____ Surgical Technician _____ Anesthesia Assistant
_____ Independent Nurse Anesthetist _____ Independent Nurse Practitioner

Have you ever failed any licensing or Board Certification or recertification examination: ____ Yes ____ No.

Do you assist in Major Surgery ____ Yes _____ No If yes, _____ on own patients only _____ on patients of others.

If yes, please describe what types of major surgery: _____

Please notify us of any changes immediately.

N. Please check any of the following that apply to your practice:

- ☐ Elective Abortions
  - ☐ Prescribe Preven, or related derivatives
  - ☐ Prescribe Mifepristone, or related derivatives in combination with cytotec
- ☐ Acupuncture
- ☐ Anesthesia
  - ☐ Spinal
  - ☐ Caudal
  - ☐ General
  - ☐ Local
  - ☐ Conscious Sedation
- ☐ Angiography
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Arteriography
- ☐ Arthroscopy
- ☐ Assist in Major Surgery
  - ☐ On Own patients
  - ☐ On Patients of Others
- ☐ Bariatric surgery
- ☐ Blepharoplasty
- ☐ Breast Biopsy
- ☐ Breast Implants
  - ☐ Cosmetic _____% of practice
  - ☐ Reconstructive _____% of practice
- ☐ Bronchoscopy
- ☐ Cardiac – major surgery
- ☐ Cardiovascular disease – major surgery
- ☐ Chelation therapy (this is excluded under this policy)
- ☐ Chemonucleolysis
- ☐ Cholecystectomy
- ☐ Cholecystectomy, Laparoscopic
- ☐ Circumcision (other than newborns)
- ☐ Colon and rectal-major surgery
- ☐ Colonoscopy
- ☐ Colposcopy
- ☐ Critical Care Specialist
- ☐ Cryosurgery (other than external lesions)
- ☐ Dermatological Surgery/Other Procedures
  - ☐ Botox
  - ☐ Chemical peels
  - ☐ Chemobrasion
  - ☐ Collagen Injections
  - ☐ Cryosurgery (superficial only)
  - ☐ Dermabrasion
  - ☐ Eye liner pigmentation
  - ☐ Fat Transfer
  - ☐ Hair transplants
  - ☐ Laser Hair Removal
  - ☐ Laser Skin Resurfacing
  - ☐ Microdermabrasion
  - ☐ Silicone Injections
  - ☐ Tumescent Liposuction
  - ☐ Other _____
- ☐ D&C
- ☐ Dermatopathology
- ☐ Echocardiography
- ☐ Electrocardiography
- ☐ Emergency medicine
- ☐ Encephalography
- ☐ Endoscopic Laser Therapy
- ☐ Endoscopy other than Proctoscopy, Sigmoidoscopy, Colposcopy and Cystoscopy
- ☐ ERCP / EGD / ERC
- ☐ Exchange Transfusions in Newborns
  How many per year? _____
- ☐ Fertility Treatment
- ☐ Fluoroscopy
- ☐ Fracture Reductions
  - ☐ Open
  - ☐ Closed
- ☐ Gastroscopy
- ☐ General – major surgery
- ☐ Gynecology – major surgery
- ☐ Hand – major surgery
- ☐ Head and neck – major surgery
- ☐ Hemorrhoidectomy
- ☐ Hernia repair
- ☐ Hip nailings
- ☐ Hospitalist
- ☐ Hyperbaric Medicine
- ☐ Hysterectomy
- ☐ Hysteroscopy
- ☐ Intensivist
- ☐ Intensive care for newborns within a Tertiary Care Unit
- ☐ Laminectomy
- ☐ Laparoscopy
- ☐ Laryngology – major surgery
- ☐ Laser Surgery
- ☐ Left Heart Catheterization
- ☐ Liposuction
- ☐ Lithotripsy
- ☐ Lumbar Fusion
- ☐ Mammography
- ☐ Myelography
- ☐ Myomectomy
- ☐ Neonatology
- ☐ Neurology – major surgery
- ☐ Norplant Insertion/Extraction
- ☐ Obstetrics/Gynecology – major surgery
  - ☐ Normal deliveries
  - ☐ C-Sections
  - ☐ VBAC
    By induction? ☐Y ☐N
    Induction agent:_____
- ☐ Ophthalmology – major surgery
- ☐ Organ Transplant
- ☐ Orthopedic – major surgery
  - ☐ With Back & Spine
  - ☐ No Back & Spine
- ☐ Osteopathic manipulative medicine
- ☐ Otology – major surgery
- ☐ Otorhinolaryngology – major surgery
  - ☐ Including elective cosmetic procedures
  - ☐ Not including elective cosmetic procedures
- ☐ Pain Management
  - ☐ Medication Only
  - ☐ IDD Therapy
  - ☐ Facet Blocks
  - ☐ Selective Nerve Root Blocks
  - ☐ Rhizotomy
  - ☐ Spinal Injections
  - ☐ Dorsal Root Gangliotomies
  - ☐ Thoracic Sympathectomies
  - ☐ Spinal Cord Stimulators
  - ☐ Implantation/Removal of Drug Infused Pumps
  - ☐ Sphenopalatine Lesioning
  - ☐ Trigeminal Lesioning
  - ☐ Cordotomies
  - ☐ Other _____
- ☐ Pedicle Screws for Spinal Surgery
- ☐ Percutaneous vertebroplasty
- ☐ Permanent Pacemaker
- ☐ Plastic – major surgery
- ☐ Polypectomy
- ☐ Prenatal Care (Past 1st Trimester)
- ☐ Prolotherapy
- ☐ Radiation/X-ray Therapy
- ☐ Radiopaque Dye
- ☐ Rapid Opiate Detoxification
- ☐ Rhinology – major surgery
- ☐ Robotics utilized
- ☐ Roux-en-y
- ☐ Sclerotherapy
- ☐ Scoliosis Surgery
- ☐ Shock Therapy
- ☐ Sterilization procedures
- ☐ Thoracic surgery _____ %
- ☐ Thyroidectomy
- ☐ Tonsillectomy/adenoidectomy
- ☐ Transgender surgery and/or hormonal gender conversion
- ☐ Trigger point injections
- ☐ Tubal ligation
- ☐ Urgent Care Medicine
- ☐ Urology – major surgery
- ☐ Vascular surgery _____%
- ☐ Vasectomy
- ☐ Weight Control _____%
  - ☐ Bariatric Bypass
  - ☐ Gastric Bubble or Jejuno-Ileal Bypass
  - ☐ Gastric Stapling
  - ☐ Gastric Banding
  - ☐ Other
  - ☐ Medications Prescribed (please list):

    _____

    _____

    _____

☐ **None of the above apply to my practice. Please initial**

_____

☐ **Other Procedures (List):**

_____

_____

_____

Coverage Sought *(Please indicate which type of coverage you are applying for).*

_____ **Occurrence Coverage**

_____ **Claims-Made Coverage without Prior Acts Coverage**.
(Check the one appropriate response below):

_____ An Extended Reporting Endorsement (tail coverage) is automatic or will be purchased from my current carrier. *Note: if previously insured on a claims-made basis, failure to obtain an Extended Reporting Endorsement will leave you without complete coverage.*

_____ My current policy is on an occurrence form.

_____ **Claims-Made Coverage with Prior Acts Coverage**.
(This is subject to approval by the basic carrier.)
Requested Retroactive Date (MM/DD/YY): _____ 12:01 a.m.
(This date cannot be greater than the retroactive date shown on your current policy.)

PCF Limits

(All limits are inclusive of underlying coverages, which coverages must be a minimum of $200,000 per occurrence/ $600,000 annual aggregate -- please indicate desired limits)

	PCF Membership Fee
❑ $1,000,000 Per Occurrence / $3,000,000 Annual Aggregate	_____
❑ $2,000,000 Per Occurrence / $4,000,000 Annual Aggregate	_____
❑ $3,000,000 Per Occurrence / $6,000,000 Annual Aggregate	_____
❑ $5,000,000 Per Occurrence / $7,000,000 Annual Aggregate	_____
❑ $10,000,000 Per Occurrence / $12,000,000 Annual Aggregate	_____

Total Membership Fee _____

- I hereby understand and agree that it is my responsibility to directly contact the PCF regarding any changes to my membership.
- I hereby agree to assist and cooperate with the PCF in all matters connected with my membership in the PCF.
- I understand and agree that my membership in the PCF is contingent on my having in force primary malpractice insurance coverage with limits not less than $200,000 per occurrence and $600,000 annual aggregate for all claims.
- I understand and agree that the limits listed herein are inclusive of all underlying coverages, unless I have been certified by the PCF as a self-insured.

- I understand and agree that my membership, along with all benefits provided to me by the PCF, will be suspended during the entire period of time that I do not have the required primary malpractice insurance coverage in force, unless I have been certified by the PCF as a self-insured.

- I understand and agree that the PCF has no obligation and will make no payments for the defense or settlement of claims or judgments for occurrences happening under occurrence based policies or claims brought under claims-made policies during the suspension period.

- I understand and agree that PCF membership shall not become effective until the PCF receives both this certificate and payment of all fees and assessments, if any, and the primary policy is in effect.

- I understand and agree that the withdrawal of my membership in the PCF requires written notice of thirty days prior to the date of withdrawal; and that I remain subject to any assessment pertaining to any year in which I participated in the PCF.

- I understand and agree that if lower limits of coverage are chosen, my coverage with the PCF ends when the annual aggregate limit is exhausted and I will be personally and financially responsible for any additional claim amounts within that membership year.

- I understand and agree that, unless previously authorized, the claims-made coverage does not cover me for any claims which occurred prior to the retroactive date if claims-made coverage is chosen.

By signing this Application for Membership in the Patients' Compensation Fund, the Named Member represents and warrants that the statements in the Application, and any subsequent notice relating to the subject of the membership agreement, are true and complete and a material part of the Certificate of Membership. The Named Member acknowledges that this Application together with the Certificate of Membership issued by the Patients' Compensation Fund will continue in force in reliance upon the truth of these representations and warranties. This Application, together with the Certificate of Membership embodies all of the agreements between the Named Member and the South Carolina Patients' Compensation Fund.

Member _____ Date _____

Broker Information *(Broker Must Sign This Application)*

I certify that I am duly licensed by an insurer authorized in South Carolina to write liability insurance other than automobile. I certify that I have reviewed this application.

_____ _____

Signature of Broker Date

Broker Name: _____ Contact Name: _____

Address:_____City: _____ State: _____ Zip: _____

Phone: _____Fax: _____ Email: _____

PCF Use Only

Current Limits: _____ Date of Review: _____

Preceptor's Limits: _____

Underwriting Comments: _____

_____

_____

The PCF membership of _____

is hereby certified effective _____ expiration _____.

Said membership is subject to the aforementioned conditions.

Date_____ Administrator _____

Please return this form and a copy of your primary declarations page to the above address, a copy will be sent to you after processing.