LOUISIANA PATIENT'S COMPENSATION FUND
SELF INSURED HEALTHCARE PROFESSIONAL APPLICATION

DATES OF ENROLLMENT APPLYING FOR: _____ **TO:** _____
Enrollment Dates - Required

I, _____ , _____
PRINT First Name, Middle Name and Last Name - Required (Professioinal Degree)

am licensed to provide professional medical services as a _____
Specialty/Designation - Required

LICENSE #: _____ **Date of Birth:** _____
License Number - Required Date of Birth - Required

EMAIL: _____

Do you work less than 20 hours per week? ____ **No** **Yes** ____ **If so, complete PCF12**

If advanced practice nurse, name of supervising MD: _____

I further certify that the appropriate security (proof of financial responsibility) is in place and current at the following institution:

_____ in the name of _____

Check 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, such as, 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, even if the underlying insurer provides coverage for same.

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.

My self insured coverage is through _____

1. Office Name, Address, Parish & Phone #

Office Name & Address Line 1 - Required

Office Name & Address Line 2

Office Address City, State & Zip Code - Required

Parish: _____

Phone # _____

2. Home Address & Phone #

Home Address Line 1

Home Address Line 2

Home Address City, State & Zip Code

Phone #: _____

3. Professional Degree

Professional Degree From _____

State/Country _____ Degree _____ Year _____

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

5. Current Specialty _____

Sub Specialties _____

Board Certified _____

6. Local Professional Society _____

7. Staff Privileges at _____

8. Name of Previous 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?** ____ **No** **Yes** ____

If yes, you must complete the corporation application (PCF9) from our website and return it.

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? If yes, complete form PCF11.**		
b. **Are you employed or contracted by a facility as a Medical Director? If yes, who is your coverage through?**		

14. **Please indicate percentage of time devoted to the following medical and/or surgical activities (total should equal 100%)**

	Addictionology		Gynecology-Surgery		Orthopedic Surgery
	Administrative Medicine		Hand Surgery		Otorhinolaryngology
	Aesthestic Medicine		Hematology		Otorhinolaryngology/Plastic
	Allergy		Hospitalist		Otorhinolaryngology/Surgery
	Anesthesiology		Infectious Diseases		Pain Management
	Bariatric Medicine		Intensive Care Medicine		Pathology
	Bariatric Surgery		Internal Medicine		Pediatrics
	Cardiac Surgery		Laborist		Pharmacology-Clinical
	Cardiovascular Disease		Neonatology		Physiatry-Phys. Med
	Cardiovascular Surgery		Nephrology		Psychiatry
	Colon & Rectal Surgery		Nephrology Interventional		Psycholanalysis
	Dermatology		Neurology		Plastic Surgery
	Emergency Medicine		Neurohospitalist		Pulmonary Diseases
	Endocrinology		Neuro-radiology		Radiology-Diagnostic
	Family Practice		Neurosurgery		Radiology-Therapeutic
	Family Practice-Incl. OB		Nuclear Medicine		Rheumatology
	Forensic Medicine		Nutrition		Sleep Medicine
	Gastroenterology		Obstetrics		Thoracic Surgery
	General Practice		Obstetrics/Gynecology		Trauma Surgery
	General Practice-Surgery		Occupational Medicine		Urgent Care Medicine
	General Preventative Medicine		Oncology-Medical		Urological Surgery
	General Surgery		Oncology-Surgery		Urology/Gynecology
	Geriatrics		Ophthalmology		Vascular Surgery
	Geriatrics/Institutional		Ophthalmology-Surgery		Wound Care
	Gynecology		Orthopedic-Office Only		
					TOTAL PERCENTAGE

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

	Acupuncture		Hysterectomies		Otorhino/Plastic
	Administer General Anesthesia		Intensive Care Medicine		Otorhino/Surgery
	Amputations - Specify		Laparoscopy		Pain Management
	Angiography		Laser Proceures - explain		Plastic Surgery
	Appendectomies		Liposuction		Saddle Blocks
	Assist in Surgical Procedures		Major Surgery in E.R.		Skin Grafts
	Bariatric/Obesity Surgery		Needle Biopsies		Spinal Anesthetics/Epidural
	Cardiac Catheterization		Nerve Blocks		Spinal Surgery
	Cardiovascular Surgery		Neurosurgery		Tonsilectomies and/or Adenoidectomies
	Cesarean Sections		Obstetrical Deliveries		Telemedicine/Teleradiology
	Colon & Rectal Surgery		Obstetrical Procedures		Thoracic Surgery
	Colonoscopy		Open Reductions of Fractures		Traumatic Surgery
	D & Cs / Abortions		Open Spinal Procedures (Non-Diagnostic)		Tubal Ligations
	Dermabrasions		Ophthalmology Surgery		Urological Surgery
	Electroshock Therapy		Oral Surgery		Vascular Surgery
	Emergency Medicine		Orthopedic Surgery w/Spine		Vasectomies
	Hand Surgery		Orthopedic Surgery - No Spine		
	Hemorrhoidectomies		Orthopedic - Minor Surgery		

16. **Do you perform x-ray or other radiation therapy?** ☐ **No** **Yes** ☐

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

10/26/2015

Date **Printed Name of Insured** Signature of Insured -- **NOT VALID WITHOUT SIGNATURE**

Any questions regarding this form may be emailed to: pcf-surcharge@la.gov

A PRINTED, SIGNED COPY OF THIS FORM MUST BE MAILED/FAXED TO PCF.

Save & Print