Locum Tenens
Application Addendum

Name of Applicant	Policy Number

In order to issue you a locum tenens policy, please complete the following questionnaire for our records. This questionnaire will become part of your malpractice insurance application.

Where is your primary place of clinical practice?

How many hours per week do you work at your primary place of clinical practice?

Please complete the following based on your locum tenens activity:

Location	Specialty	# Hours per week
1.		
2.		
3.		
4.		

I HEREBY CERTIFY UNDER THE PAINS AND PENALTIES OF PERJURY THAT THE FOREGOING REPRESENTATIONS ARE TRUE AND THAT THEY ARE MADE BY ME IN ORDER TO RECEIVE A CREDIT ON MY OTHERWISE APPLICABLE PREMIUM FOR MEDICAL MALPRACTICE INSURANCE COVERAGE. I AGREE TO REPORT ANY CHANGE IN THE DURATION OR NATURE OF MY PRACTICE WHICH MAY AFFECT MY ELIGIBILITY FOR A LOCUM TENENS CREDIT TO THE UNDERWRITING STAFF OF EmPRO AS SOON AS ANY CHANGE OCCURS. I AGREE TO ALLOW EmPRO TO VALIDATE THE ABOVE INFORMATION AS IT MAY DEEM NECESSARY.

Signature of Physician

Title

Printed Name of Physician

Date

Signature of Producer (signature is required for N.H. producers only)

Dale

Printed Name of Producer

If you have any questions regarding the completion of this questionnaire, please contact the Underwriting Department.