Professional Liability Coverage Application – New Applicant

You must be a member of the CDA or have application pending and you must maintain CDA membership

All policies issued are claims-made for the policy period. No coverage exists for claims first made after the end of the policy period, unless, and to the extent, an extended reporting period applies.

1. Please answer all questions. Do not leave blanks. If a question is not applicable, please write N/A.
2. Please sign and date the application.
3. Requested Effective Date: _____/_____/_____
4. Referred by:_____

General Information

1. Full Name of Applicant:_____

   ☐DDS ☐DMD ☐MD ☐BDS ☐MS ☐JD

2. Date of Birth: _____/_____/_____ ☐Male ☐Female

3. Tax I.D.#_____

4. Mailing Address:

   _____

   Street City State Zip

5. Practice Address:

   _____

   Street City State Zip

6. Contact Information:

   Office (_____)_____ Home (_____)_____

   Cell (_____)_____ Fax (_____)_____

   Email _____ Web Page _____

   Preferred contact method: _____

Professional Information

7. Colorado Dental License #_____ DEA#_____ Expiration Date ____/_____
8. Have you ever been licensed in another state? List all

   License # _____ Current? ☐Yes ☐No
9. Dental School Attended _____
10. Month/Year of Graduation _____/_____
11. If you are a Foreign Dental School Graduate, are you certified by the Educational Council for Dental School Graduates: ☐Yes ☐No If yes, year of certification _____
12. Have you completed a residency? Please list _____ Date Completed _____/_____
13. Please list any other Professional Licenses:

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14. In consideration of the issuance of this coverage, the applicant agrees to become a member of the Colorado Dental Association and maintain membership. _____(initials)

    What professional organizations are you a member of? ☐ADA ☐CDA (required)

    Other: _____

About Your Practice:

☐Employee Dentist ☐Individual ☐Partnership ☐Professional Corporation ☐Contract Dentist

Name of Practice: _____

Additional Locations: _____

Name of Partners or Members of Corporation/Employer_____

Are other dentists employed or contract providers employed by you? ☐Yes ☐No Number Employed____

Are they Trust Dentists? ☐Yes ☐No

License and Claims History

15. Do you have hospital privileges? ☐Yes ☐No

Please provide details: _____

List Dental Assistants: _____

16. Has any dental school or governmental agency, including a state licensing board, ever taken action against either your dental and/or narcotics license including suspension, revocation, probation, restriction, voluntarily surrendered, denial or other sanctions? ☐Yes ☐No

If yes, provide a copy of the board transcript or other documentation, including resolution.

17. Have you ever been denied a dental license or been denied certification by a specialty board?

☐ Yes ☐No

If yes, provide details: _____

18. Have you been under investigation or currently under investigation by any governmental agency including a state licensing board or other regulatory agency including Peer Review? ☐Yes ☐No

If yes, provide a copy of the board transcript or other documentation, including resolution.

19. Have you been convicted of any criminal charges? ☐ Yes ☐ No

Please provide details: _____

20. Have you ever been or are you currently being treated for:

Alcohol abuse	☐Yes	☐No
Drug Addiction	☐Yes	☐No
Mental Illness	☐Yes	☐No
Physical Disablement	☐Yes	☐No

If yes, provide a letter from treating physician with complete details.

21. Has any claim or suit for alleged malpractice ever been brought against you? ☐ Yes ☐No

If yes, please provide details and copies of settlement.

22. Are you currently aware of any situation that could lead to a malpractice suit against you? ☐Yes ☐No

If yes, provide details: _____

23. Retroactive Coverage.

Carrier and dates covered: _____

Retroactive Coverage Desired: *Be exact by day* _____to_____

Procedures Performed

24. Indicate which of the following areas you plan to practice:

☐ Examination, diagnosis, treatment planning
☐ Implantology ☐ Surgical ☐ Restorative
☐ Pediatric Dentistry
☐ Operative Dentistry
☐ Orthodontics
☐ Endodontics
☐ Periodontics
☐ Neurotoxins and Dermal Fillers
☐ Preventive Dentistry
☐ Prosthodontics, Fixed
☐ Prosthodontics, Removable
☐ Oral Surgery
☐ Cosmetic Dentistry
☐ TMJ/TMD
☐ Hospital Dentistry
☐ Deep Sedation

25. Indicate the following dental techniques or procedures you perform, or someone under your direct supervision/direction will perform:

☐ Sleep Apnea Therapy
☐ Lasers – used in dental treatment
☐ Extraction of Impacted Teeth
☐ Physical Therapy
☐ Molar Endodontics
☐ Implant Dentistry (If yes, provide copies of training and certificates)
  ☐ Surgical Placement (please complete Implant Application)
  ☐ Restorative
☐ Sedation (If yes, provide the required State documentation and complete Anesthesia/Sedation Application)
  ☐ General Anesthesia
  ☐ Moderate Sedation
  ☐ Minimal Sedation
  ☐ Nitrous Oxide/Oxygen Inhalation
  ☐ Oral Premedication for anxiety & apprehension

Who administers the anesthesia?

☐ You

☐ Another Dentist or MD Anesthesiologist or CRNA

☐ Comprehensive Radiographic Survey (FMX)? ☐ Yes ☐ No

How frequently? _____

☐ CT Imaging

Is the equipment used on patients other than your own? ☐ Yes ☐ No

Are the results read by a radiologist? ☐ Yes ☐ No

☐ Cosmetic Dentistry/Rehabilitation/TMJ/TMD (If yes, please copies of any training)

☐ Botox/Dermal procedures (If yes, provide copies of training and certification and complete Application)

26. Do you obtain a dental/medical history for all patients? ☐ Yes ☐ No

27. Do you personally review it? ☐ Yes ☐ No

Is that history updated? ☐ Yes ☐ No

How frequently? _____

28. Do you complete patient charts? ☐ Yes ☐ No

☐ Immediately after treatment ☐ End of each day ☐ End of each week

29. Do you have written informed consent documents in your office? ☐ Yes ☐ No
If yes, list for what procedures: _____

30. Do you record a comprehensive/detailed treatment plan in the patient's chart? ☐ Yes ☐ No

Do you have a patient consultation of your treatment plan that is approved and signed by the patient? ☐ Yes ☐ No

31. Do you have established emergency procedures, personnel trained in BLS and equipment for patient emergencies such as cardiac arrest, etc? ☐ Yes ☐ No

*Please provide details:*_____

CPR Certification Date _____

☐ AED ☐ Emergency Kit

SUPPLEMENTAL REPORT FORM

As indicated in Questions 16, 21, 22 of the Professional Liability Coverage Application, the following information is required. Complete a separate form for each incident/claim or suit regardless of the disposition of the complaint, claim or incident.

(make copies of this form if you need to report multiple incidents/claims or complaints)

1. Name, age and sex of patient: _____
2. Date of first examination: _____
3. Dental condition and diagnosis at first examination: _____

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4. Dates of treatment and nature of treatment: _____
5. Date of incident/claim, and allegations made _____
6. Disposition of the incident/claim and amount of judgement or settlement _____
7. What insurance company, if any, was involved: _____
8. Subsequent condition/health of the patient: _____
9. Name of other doctors, if any, involved in the incident/claim or suit: _____
10. To whom may we refer for further information about the claim/suit: _____

_____ Signed

_____ Dated