[ ] **Evanston Insurance Company**
[ ] **Markel American Insurance Company**
[ ] **Markel Insurance Company**

APPLICATION FOR LOCUM TENENS AND CONTRACT STAFFING ORGANIZATIONS PROFESSIONAL AND GENERAL LIABILITY

Notice: The Professional Liability coverage for which application is made is claims made coverage: coverage applies only to “Claims” first made during the "Policy Period," unless the Extended Reporting Period is exercised.

If the General Liability coverage for which application is made is claims made coverage: cover will apply to “Claims” first made during the "Policy Period," unless the Extended Reporting Period is exercised."

Unless amended by endorsement, the limits of liability shall be reduced by “Claim Expenses” and “Claim Expenses” shall be applied against the deductible.

Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. Full name of Applicant organization: ____________________
2. Principal business premise address: ____________________
   (Street) (County)
   ____
   (City) (State) (Zip)
3. (a) Phone:____________________ (b) E-Mail Address:____________________
   (c) Website Address: ____________________
4. [ ] Corporation [ ] Limited Liability Corporation [ ] Partnership [ ] Other
5. Number of years under present ownership: ____________
6. Corporate Medical Director: ____________________
   Name
7. Corporate Credentialing Contact: ____________________ ____________
   Name Phone
6. Number of employees: Full time ________ Part time ________
7. Proposed inception date of insurance: __________
8. Is the Applicant a “Covered Entity” under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule?.......... [ ] Yes [ ] No
   If Yes,
   (a) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule? .... [ ] Yes [ ] No
   (b) Provide the name and title of the Applicant’s Privacy Officer.____________________
   Our Business Associate Agreement is available at https://www.markelcorp.com/US-Insurance/HIPAA. This is the only Business Associate Agreement we will recognize.

II. PROFESSIONAL SERVICES

1. Coverage is requested for:
   [ ] Locum Tenens Organization If the Applicant is a Locum Tenens Organization, complete Section A.
   [ ] Contract Staffing Organization If the Applicant is a Contract Staffing Organization, complete Section B.
2. (a) Estimated annual gross revenues for the coming year: $____________
   (b) Annual gross revenues for:
   (a) last twelve months: Year:________ $__________
   (b) 1st prior year: Year:________ $__________

A. LOCUM TENENS Complete this section if the Applicant is a Locum Tenens Organization.

1. Type of facility where the Applicant provides staffing services. Check all that apply:
   [ ] Hospital [ ] Surgery Center [ ] Clinic [ ] FTCA deemed Clinic [ ] Correctional Facility
   [ ] Physician Office [ ] Clinical Trial [ ] Other____________________

2. Does the Applicant provide medical staff in any Patient Compensation Fund (PCF) state? .... [ ] Yes [ ] No
   (a) If Yes, check all that apply: [ ] IN [ ] KS [ ] LA [ ] NE [ ] NM [ ] PA [ ] SC [ ] WI

3. Does the Applicant provide medical staff in:
   (a) New York? .... [ ] Yes [ ] No
   (b) Virginia? .... [ ] Yes [ ] No

4. Does the Applicant require all employed and contracted healthcare providers to carry Professional Liability Insurance? .... [ ] Yes [ ] No
   (a) If Yes, how often is Professional Liability Insurance coverage verified? ____________
   (b) Provide the minimum limits of liability that the Applicant requires. $________ per claim/ $_________ aggregate

5. Is the Applicant a member of the National Association of Locum Tenens Organization (NALTO)? ...... [ ] Yes [ ] No

6. Provide the following for the last five years:

Year	Annual Total No. of Locum Days or Hours		
___________	_________________	[ ] days	[ ] hours
___________	_________________	[ ] days	[ ] hours
___________	_________________	[ ] days	[ ] hours
___________	_________________	[ ] days	[ ] hours
___________	_________________	[ ] days	[ ] hours

7. Complete the attached Schedule of Medical Specialties for all healthcare providers.

B. CONTRACT STAFFING Complete this section if the Applicant is a Contract Staffing Organization.

1. List the hospitals/facilities the Applicant currently contracts with or plans to contract within the next twelve months:

Name	Location

2. Does the Applicant utilize Locum Tenens? .... [ ] Yes [ ] No
   (a) If Yes, provide the name of the Locum Tenens organization: ____________________

3. Does the Applicant provide medical staff in any Patient Compensation Fund (PCF) state? .... [ ] Yes [ ] No
   (a) If Yes, check all that apply: [ ] IN [ ] KS [ ] LA [ ] NE [ ] NM [ ] PA [ ] SC [ ] WI

4. Does the Applicant provide medical staff in:
   (a) New York? .... [ ] Yes [ ] No
   (b) Virginia? .... [ ] Yes [ ] No

5. Complete the attached Contract Staffing Schedule.

III. RISK MANAGEMENT PROCEDURES

1. Does the Applicant have a formal professional liability risk management program?
   .... [ ] Yes [ ] No [ ] Informal program only
   If Yes,
   (a) Provide details of the current risk management program.____________________
   ____
   (b) Does the Applicant have a risk manager to coordinate its risk management program?
   [ ] Designated risk manager with a formal job description.*
   [ ] Designated risk manager without a formal job description.*
   [ ] No designated risk manager.

* If the Applicant has a designated risk manager provide a copy of the risk manager's job description and resume.

2. Does the Applicant:
   (a) Credential its own healthcare providers? .... [ ] Yes [ ] No
   (b) Provide credentialing services to other healthcare organizations for a fee? .... [ ] Yes [ ] No

3. Is the Applicant a NCQA or URAC accredited credentialing organization? .... [ ] Yes [ ] No

4. (a) Does the Applicant have guidelines/protocols for evaluating, selecting and contracting with healthcare providers? .... [ ] Yes [ ] No
   (i) If Yes, check all that apply:
   - [ ] Drug Testing
   - [ ] Criminal Background Checks – Federal & State
   - [ ] Reference Checks
   - [ ] Personal Interview
   - [ ] Sexual Abuse Registry
   - [ ] Validate Work History, Education
   - [ ] Validate Current License/Certification
   - [} Validate claim history and disciplinary actions

   (b) Does anyone other than the Applicant's Medical Director have the authority to make determinations on the eligibility of healthcare providers that fall outside of the Applicant's screening guidelines/protocols for assignments? .... [ ] Yes [ ] No
   (i) If Yes explain. ______________________________

5. Are all physicians/healthcare providers licensed in the states where services are rendered including those services exchanged via electronic communication (telemedicine)? .... [ ] Yes [ ] No

6. Does the Applicant have an incident reporting process? .... [ ] Yes [ ] No
   (a) If Yes, provide the name and title of the person responsible:______________________________

7. Is a practice profile completed for each facility that a healthcare provider(s) may be placed prior to assignment? .... [ ] Yes [ ] No

8. Does the Applicant have procedures to monitor the quality of patient care provided by the healthcare provider placed in various settings, i.e., hospitals, physician offices, clinics? .... [ ] Yes [ ] No

9. Does the Applicant have a formal process for claims review?
   [ ] Formal claims review as part of risk management system.
   [ ] Formal claims review system separate from risk management.
   [ ] No claims review.

IV. INSURANCE AND CLAIMS HISTORY

1. (a) Limits of Liability for Professional Liability - Indicate the limits of liability requested:

   Per Claim/Coverage Aggregate

   [ ] $ 100,000 / $ 300,000
   [ ] $ 200,000 / $ 600,000
   [ ] $ 250,000 / $ 750,000
   [ ] $ 500,000 / $1,500,000
   [ ] $1,000,000 / $3,000,000
   [ ] Other:__________________________

   Professional Liability Policy Aggregate: $__________

   (b) Deductible - Indicate deductible requested:
   [ ] $5,000 [ ] $10,000 [ ] $15,0000 [ ] $25,000 [ ] $50,000 [ ] other __________
   (c) Is coverage requested for prior acts? .... [ ] Yes [ ] No
   (i) Is Yes, requested Retroactive Date: _____________

THE COMPANY DOES NOT GUARANTEE TO OFFER ANY OF THE ABOVE LIMITS, DEDUCTIBLES AND/OR RETROACTIVE DATE.

2. List prior Professional Liability Insurance carried for each of the last five years, including the current year.
   If None, check here. [ ]

Ins Company	Limits of Liability	Deductible	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

3. Has the Applicant or any employed or contracted healthcare providers:
   (a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? .... [ ] Yes [ ] No
   (b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? .... [ ] Yes [ ] No
   (c) Even been treated for alcoholism or drug addiction? .... [ ] Yes [ ] No
   (d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? .... [ ] Yes [ ] No
   (e) Ever had any insurance company or Lloyd's cancel, decline, refuse to renew or accept only on special terms their malpractice insurance? .... [ ] Yes [ ] No

   If Yes to (a) – (e), provide details by attachment.

4. Is the Applicant or any employed or contracted healthcare provider aware of any act, error, omission, fact, circumstance, situation or incident which may result in a disciplinary or investigative proceeding by a governmental or administrative agency? .... [ ] Yes [ ] No
5. Has any claim or suit for alleged malpractice been brought against the Applicant or any employed or contracted healthcare provider rendering services for or on behalf of the Applicant? .... [ ] Yes [ ] No
   (a) If Yes, provide currently valued 5-year company loss runs or complete a copy of our Supplemental Claim form for each claim or suit.
6. Has any claim or suit for alleged malpractice been made against the applicant or any employed or contracted healthcare provider rendering services for or on behalf of the Applicant that has not been reported to a prior insurer? .... [ ] Yes [ ] No
   (a) If Yes, complete a copy of our Supplemental Claim Information form for each claim or suit.
7. Is the Applicant aware of any act, error, omission, fact, circumstance, situation or incident which may result in a malpractice claim or suit being made or brought against the Applicant or any employed or contracted healthcare provider rendering services for or on behalf of the Applicant organization? .... [ ] Yes [ ] No
   (a) If Yes, complete a copy of our Medical Incident Form for each incident.

V. GENERAL LIABILITY (To be completed by the Applicant if applying for General Liability.)

A. GENERAL INFORMATION

1. Complete the following for each of the Applicant's facilities:

Location Number	Name of Facility	Address of Facility	Description (Yes/No)	Does the Applicant Maintain a Garage? (Yes/No)	Is There an Adjacent Exposure? (Yes/No)
1					
2					
3					
4					

2. Does the Applicant maintain office space at a host facility? .... [ ] Yes [ ] No
3. Complete the following for each of the Applicant's locations:

	Location 1	Location 2	Location 3	Location 4
Square Footage*	________	________	________	________
Year Built	________	________	________	________

Year Remodeled	_________	_________	_________	_________
Number of Stories	_________	_________	_________	_________
Type of Construction (frame, brick, concrete)	_________	_________	_________	_________
Percentage of Building Occupied by Applicant	_________	_________	_________	_________
Other occupants? (Yes/No)	_________	_________	_________	_________

*Include square footage of parking facilities if owned or rented by the Applicant.

4. Are all of the Applicant's locations equipped with:
   (a) Complete Sprinkler System? .... [ ] Yes [ ] No
   (b) At least two clearly marked exits on each floor? .... [ ] Yes [ ] No
   (c) Smoke detectors? .... [ ] Yes [ ] No
   (d) Emergency electrical system? .... [ ] Yes [ ] No
   (e) Heat sensors? .... [ ] Yes [ ] No
   (f) Fire escape(s)? .... [ ] Yes [ ] No
   (g) Posted emergency evacuation procedures? .... [ ] Yes [ ] No
   (h) Properly maintained fire extinguishers? .... [ ] Yes [ ] No

   If any of the above are answered No, provide details by attachment.

5. Does the Applicant have a written safety program in place? .... [ ] Yes [ ] No
   (a) If Yes, attach a copy of the written safety program.

6. Does the Applicant have written procedures for incident reporting? .... [ ] Yes [ ] No

7. Do any of the Applicant's locations have any:
   (a) Exposure to flammables, explosive, chemicals? .... [ ] Yes [ ] No
   (b) Catastrophe exposure? .... [ ] Yes [ ] No
   (c) Exposure to radioactive materials? .... [ ] Yes [ ] No

8. Do any of the Applicant's operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials? .... [ ] Yes [ ] No

9. Does the Applicant sell or lease any medical equipment or products to patients or others in connection with Applicant's operation? .... [ ] Yes [ ] No
   If Yes,
   (a) Total Annual Sales $____________
   (b) Total Annual/Lease Rental Receipts $____________

10. Does the Applicant:
    (a) Loan or rent machinery or equipment to others? .... [ ] Yes [ ] No
    (b) Own any elevators or escalators? .... [ ] Yes [ ] No
    (c) Own or rent any parking facility? .... [ ] Yes [ ] No
    (d) Provide any recreational facility? .... [ ] Yes [ ] No
    (e) Have a swimming pool on the premises? .... [ ] Yes [ ] No
    (f) Sponsor any sporting or social events? .... [ ] Yes [ ] No
    (g) Own or rent space used for housing for any healthcare provider? .... [ ] Yes [ ] No

    If Yes to (a)-(g), provide details by attachment.

B. INSURANCE AND CLAIMS HISTORY

1. (a) Limits of Liability for General Liability - Indicate the limits of liability requested:

   Per Occurrence/Coverage Aggregate

   [ ] $ 100,000 / $ 300,000

   [ ] $ 200,000 / $ 600,000

   [ ] $ 250,000 / $ 750,000

   [ ] $ 500,000 / $1,500,000

   [ ] $1,000,000 / $3,000,000

   [ ] Other:__________________________

   (b) Deductible - Indicate deductible requested:
   [ ] $5,000 [ ] $10,000 [ ] $15,0000 [ ] $25,000 [ ] $50,000 [ ] other __________

THE COMPANY DOES NOT GUARANTEE TO OFFER ANY OF THE ABOVE LIMITS AND/OR DEDUCTIBLES

2. (a) Type of coverage requested; [ ] Claims Made [ ] Occurrence
   (b) If claims made coverage requested, is coverage requested for prior acts? .... [ ] Yes [ ] No
      (i) If Yes, requested Retroactive Date: ___________________

3. Does the Applicant currently have coverage for:
   (a) Hired and Non-Owned Auto Liability? .... [ ] Yes [ ] No
      (i) If Yes, provide the limits of liability currently carried. $__________/$_________
      If the Applicant wants coverage for Hired and Non-Owned Auto Liability complete our Supplement for Hired and Non-Owned Auto Liability (SM-10003).
   (b) Employee Benefits Liability? .... [ ] Yes [ ] No
      (i) If Yes, provide the limits of liability, deductible and retroactive date currently carried.
      Limits of Liability: $_________/$________ Deductible: $__________ Retroactive Date:___________
      If the Applicant wants coverage for Employee Benefits Liability complete our Supplement for Employee Benefits Liability (ZZ-31002-01).

4. Does the Applicant want coverage for any additional insureds? .... [ ] Yes [ ] No
   If Yes, list any additional insureds that coverage is requested for and the relationship to the Applicant.

   ____

5. List prior General Liability Insurance carried for each of the last five years, including the current year.
   If None, check here. [ ]

Ins Company	Limits of Liability	Deductible	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

6. Has any claim for General Liability ever been made against any person(s) or organization(s) proposed for this insurance? .... [ ] Yes [ ] No
   (a) If Yes, provide currently valued 5-year year loss runs or complete a copy of our Supplemental Claim Information form for each one.

7. Is (are) any person(s) or organization(s) proposed for this insurance aware of any fact, circumstance, situation or incident which may result in a General Liability claim, such as would fall under the proposed insurance? .... [ ] Yes [ ] No
   (a) If Yes, complete a copy of our Supplemental Claim Information form for each one.

VI. ADDITIONAL INFORMATION

(a) Curriculum Vitae (CV) for the Applicant Organization's Medical Director, including specialty and board certification.
(b) Risk Management protocols.
(c) Most recent annual financial statements.
(d) Sample contract for healthcare providers and facilities.
(e) If coverage requested for Hired and Non-Owned Auto Liability complete our Supplement for Hired and Non-Owned Auto Liability (SM-10003).
(f) If coverage requested for Employee Benefits Liability complete our Supplement for Employee Benefits Liability (ZZ-31002-01).

Note: If the Applicant does not purchase prior acts coverage from the Company there will be no coverage with the Company for any claim, suit or circumstance based upon the rendering or failure to render professional services prior to the effective date of the Applicant's policy, if issued.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

No fact, circumstance or situation indicating the probability of a "Claim" or action for which coverage may be afforded by the proposed insurance is now known by any person(s) or organization(s) proposed for this insurance other than that which is disclosed in this application. It is agreed by all concerned that if there is knowledge of any such fact, circumstance or situation, any "Claim" subsequently emanating therefrom shall be excluded from coverage under the proposed insurance.

This application, information submitted with this application and all previous applications related hereto and material changes to any of the foregoing of which the underwriting manager, Company and/or affiliates thereof receives notice is on file with the underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy.

For the purpose of this application, the undersigned authorized agent of the person(s) and organization(s) proposed for this insurance declares that to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this application and in any attachments, are true and complete. The underwriting manager, Company and/or affiliates thereof are authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the underwriting manager, Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

If the coverage for which application is made is for claims made coverage, the undersigned declares that the person(s) and organization(s) proposed for this insurance understand that:

(i) The coverage for which application is made applies only to "Claims" first made during the "Policy Period."

(ii) Unless amended by endorsement, the limits of liability contained in the policy shall be reduced, and may be completely exhausted by “Claim Expenses” and, in such event, the Company will not be liable for “Claim Expenses” or the amount of any judgment or settlement to the extent that such costs exceed the limits of liability in the policy; and

WARRANTY

I warrant to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

Must be signed by the Applicant within 60 days of the proposed effective date.

______________________________	______________________________
Name of Applicant	Title
______________________________	______________________________
Signature of Applicant	Date

Notice to Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

Contract Staffing Schedule Complete this schedule if the Applicant is a Contract Staffing Organization.

		Staffing Emergency Room (ER) or Urgent Care (UC)						Staffing Correctional	
		Current Annual No. Visits		Projected Annual No. of Visits		Current Annual FTEs	Projected Annual FTEs	Current ADI	Projected ADI
State	Medical Specialty	ER	UC	ER	UC				

FTE = Full Time Equivalent means the total number of physician provider hours equal to one full-time physician. A full time physician is defined as 8 hours per day for all physician specialties except Emergency Medicine, Hospitalist, Neonatology, for these specialties 1 day equals 12 hours
ADI = Average Daily Inmate

Schedule of Individual Healthcare Providers

State	Name of Provider	Medical Specialty	Provider's Start Date	Provider's Termination Date

Schedule of Medical Specialties for Healthcare Providers

			Current Year Hours or Days		Projected Annual Hours or Days	
	Specialty	State(s)	Hours	Days	Hours	Days
80166	Abdominal Surgery (Major Surgery)					
80437	Acupuncture					
80250	Aerospace Medicine					
80254	Allergy					
80151	Anesthesiology					
80476	Bariatric Surgery					
80141	Cardiac-Surgery					
80281A	Cardiology – Catheterization or other invasive procedures					
80255	Cardiology – no surgery/no invasive procedures					
20255	Cardiovascular Disease – no surgery					
80150	Cardiovascular Disease – surgery					
80115	Colon & Rectal Surgery					
80443	Colonoscopy/Endoscopy					
80256A	Dermatology- No Surgery/No laser					
80252	Dermatology - including laser therapy					
80256B	Dermatology doing excision of skin lesions with graft or flap; collagen injections.					
80472	Dermatology – Major Surgery					
80474	Dermatopathology					
80237	Diabetes – no surgery					
80102	Emergency Medicine – no major surgery					
80102C	Emergency Medicine practitioner at a clinic, hospital or rescue facility					
80102A/B	Emergency Medicine – Moonlighting					
80238	Endocrinology – no surgery					
80423	Family Practitioner - no surgery,or OB					
80421J	Family Practitioner - OB, minor surgery, induced abortions					
80117d	Family Practitioner – OB and major surgery					
80240	Forensic Medicine/Legal					
80241	Gastroenterology- no surgery					
80274	Gastroenterology- minor surgery					
80104	Gastroenterology- major surgery					
80231	General Preventive Medicine – no surgery					
80276	General Preventive Medicine – minor surgery					
80243	Geriatrics – no surgery					
80276	Geriatrics – minor surgery					
80244	Gynecology – no OB/no surgery					
80277	Gynecology – no OB/minor surgery					

			Current Year Hours or Days		Projected Annual Hours or Days	
	Specialty	State(s)	Hours	Days	Hours	Days
80167	Gynecology – major surgery					
80169	Hand Surgery					
80245	Hematology – no surgery					
80278	Hematology – minor surgery					
80222 A	Hospitalist – no minor assist in major surgery on own patients					
80222 B	Hospitalist perform minor assist in major surgery on own patients					
80233	Industrial Medicine					
80246	Infectious Diseases no surgery					
80279	Infectious Diseases minor surgery					
80283	Intensive Care Medicine					
80257	Internal Medicine – no surgery					
80284	Internal Medicine – minor surgery					
80285	Laryngology – minor surgery					
80245B	Laser Surgery					
80298	Neonatology – no surgery					
80261	Neurology – no surgery					
80288	Neurology – minor surgery					
80152	Neurology Surgery					
80152	Neurosurgery					
80248	Nutrition					
80262	Nuclear Medicine					
80153	Obstetrics/Gynecology					
80233	Occupational Medicine					
80473	Oncology –no surgery/no invasive procedures					
80286	Oncology –minor surgery/ invasive procedures					
80263	Ophthalmology - no surgery					
80289	Ophthalmology – minor surgery					
80114	Ophthalmology – surgery					
80154A	Orthopedic Surgery – No Spinal Surgery					
80154B	Orthopedic Surgery – Spinal Work					
80158	Otology					
80265	Otorhinolaryngology - no surgery					
80291	Otorhinolaryngology – minor surgery					
80159	Otorhinolaryngology – major/no-plastic					
80475B	Pain Management - Basic					
80475C	Pain Management - Intermediate					
80475D	Pain Management – Advanced					
80266	Pathology/no surgery/no invasive procedures					
80267	Pediatrics – no surgery/no invasive procedures					
80293	Pediatrics – minor surgery					
80249	Psychiatry (including child)- no shock therapy/no surgery/no invasive procedures,					
80161	Psychiatry Shock Therapy					
80268	Physicians - no surgery					

			Current Year Hours or Days		Projected Annual Hours or Days	
	Specialty	State(s)	Hours	Days	Hours	Days
80294	Physicians - minor surgery					
80156	Plastic Surgery					
80236	Public Health					
80269	Pulmonary Disease – no surgery/no invasive procedure					
80269B	Pulmonary Disease – no surgery/minor procedures; assist					
80253b	Radiology					
80253	Radiology – diagnostic only/no radiation therapy.					
80280	Radiology – diagnostic only/minor assist.					
80360	Radiology – Invasive Interventional/Radiation Therapy					
80425	Radiation Therapy					
80252	Rheumatology					
80144	Thoracic Surgery					
80171	Traumatic Surgery					
80145A	Urology – no surgery					
80145B	Urology – minor surgery					
80145C	Urology Surgery					
80146	Vascular Surgery					
80242	Urgent Care Medicine – no ER/no surgery					

ADVANCED PRACTICE PROVIDERS

		Current Year Hours or Days		Projected Annual Hours or Days	
Specialty	State(s)	Hours	Days	Hours	Days
Certified Registered Nurse Anesthetist (CRNA)					
Dentists					
Nurse Practitioner – emergency room					
Nurse Practitioner – no emergency room, no OB					
Oral Maxillofacial Surgery					
Pharmacist					
Psychologist					
Physical Therapist					
Physician Assistant – emergency room					
Physician Assistant – no emergency room					
Podiatrists					
Other:					