LOUISIANA PATIENTS' COMPENSATION FUND
SELF INSURED PHYSICIAN APPLICATION

I, ____, ________, am licensed
(First name, middle name and last name) (Prof. Degree)

to provide professional medical services as a________________________________.
(Specialty or designation)

LICENSE NUMBER: ______________________ DATE OF BIRTH _____________

RENEWAL APPLICATIONS ONLY: I hereby certify that there have been no changes in any aspect addressed by this form since my last completed application to the LA PCF:

_________________________________ ____________________
Signature Date

1. Office Address (no P.O. Box): ______________________________________

   ____

   Telephone ______________________________________

   City ______________________________________

   Parish ______________________________________

   State/Zip ______________________________________

2. Home Address: ______________________________________

   ____

   ____

3. Professional degree from ______________________________________

   County________________ Degree________________ Year______________

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

   ____

   ____

5. Present Specialty ________________________ Sub-specialties______________

   Board Certified____

6. Local professional society____

7. Staff privileges at ____

____

8. Name of Professional liability carrier____________________________________

9. I am not employed by any physicians group, firm, hospital or corporation except as follows: (if no exception, so state)

____

____

10. List names of any healthcare providers employed by your or by any medical partnership or corporation with which you are professionally involved (including, but not limited to, nurse technicians, CRNAs, physicians assistants):

____

____

11. List names of any partners (if applicable): ______________________________

____

12. Are you a stockholder in a professional medical corporation?_________________

____

Name of corporation____

Trade Names/DBAs (if any) ____

13. Please indicate answers to questions below. Fully explain any "yes" answer in the space allowed.

	YES	NO
a. Has membership in any professional association or society ever been revoked		
b. Has any hospital suspended, restricted or refused you staff privileges?		
c. Have you ever voluntarily surrendered or had a state license to practice medicine refused, suspended or revoked?		
d. Have you ever voluntarily surrendered or had a narcotics license refused, suspended or revoked?		
e. Have you ever been treated for alcoholism, narcotic addiction or mental illness?		
f. Have you ever been convicted of a crime?		
g. Have you ever had any chronic or physical defect?		
h. Have you ever had any professional liability insurance refused, cancelled or non-renewed?		
i. Do you work in an emergency room or industrial medical facility?		
j. Do you own, operate or supervise the operation of any hospital or sanitarium?		
k. Have any claims or suits been filed against you during the past 5 years as a result of professional services rendered?		

Details on "yes" answers (please identify by letter): ____________________________

____

____

14. Check which, if any, of the following procedures you perform:

	Cosmetic plastic surgery		Cosmetic breast implantation
	Hair transplants		Dermabrasions
	Skin planning		Cosmetic chemo surgery
	Angiography		Cardiac catheterization
	Electroshock therapy		Vasectomies
	Tubal ligations		Insertion of I.U.D.s
	Prescribing contraceptives		Weight control (other than diet)
	T&A's		D&Cs
	Appendectomies		Hysterectomies
	Hemorrhoidectomies		Open reductions of fractures
	Obstetrical deliveries		Cesarean sections
	Assist in surgery		Open spinal procedures (non diagnostic)
	Major surgery in E.R.		Office x-rays
	Administer general anesthesia		Spinal anesthesia
	Caudals		Saddle blocks

15. Do you perform x-ray or other radiation therapy? ___________________________

    If so, please list x-ray technicians employed by you: ________________________

    ____

    ____

    Radium technicians employed by you: ___________________________________

    ____

16. Your attention is directed to LAC 37: III, Chapter11, §§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.

SIGNED: ____DATE: _______________