

Medical Malpractice Reinsurance Program

Affidavit for Nurse Practitioners – Calendar Year 2010 - **Submission Deadline 12/31/09**

NOTE: If your malpractice coverage is provided through a health care facility and you are employed by that facility, you are not eligible to participate in this program.

(A health care facility is defined in ORS 442.015 as a hospital, a long term care facility, an ambulatory surgical center, a freestanding birthing center or an outpatient renal dialysis facility)

PLEASE COMPLETE APPLICABLE SECTIONS OF FORM, SIGN AND FAX TO (503) 494-4798
(or insert an electronic signature and e-mail to pepplerl@ohsu.edu)

1. Your full name (First, MI, Last): _____

2. Email: _____ Office phone: _____

3. Professional Specialty: _____ OSBN Certification number _____

4. Are you employed by a licensed physician? yes no 4a. Are you certified to provide obstetric care? yes no

5. Professional liability insurance carrier name: (check one) Policy number: _____

- _____ CNA-NSO
- _____ NW Physicians Insurance Company
- _____ OMA-CNA
- _____ Preferred Professional Insurance Company
- _____ The Doctors Company
- _____ The Medical Protective Insurance Company

You must be named individually on your policy and the premium must be calculated separately. (No shared limits).

6. **CURRENT PRIMARY** practice **mailing** address:

Mailing Address: _____

City: _____ County: _____ State: _____ Zip code: _____

Number of hours spent weekly in this location (please do not include time on call or travel time) _____ hrs

a. **CURRENT SECONDARY** practice **mailing** address (if applicable):

Mailing Address: _____

City: _____ County: _____ State: _____ Zip code: _____

Number of hours spent weekly in this location (please do not include time on call or travel time) _____ hrs

b. **ADDITIONAL PRACTICE SITES?** Please list by attaching an additional sheet.

7. Has your practice and/or liability carrier & policy number **CHANGED** since January 1 of 2009? yes no

If yes, what was the date of your practice change? _____

I attest that I am willing to serve Medicare and Medicaid patients in at least the same proportion to the total number of my patients as the Medicare and Medicaid populations represent to the total number of people in the rural areas of the county in which I practice. (See enclosed listing of proportions by county.) ***Note: This is not applicable if you checked "yes" on item 4 above.**

I hereby certify that all information supplied in this affidavit is accurate to the best of my knowledge. I understand that if my practice location or insurance carrier changes, I must notify the Office of Rural Health within 10 days of the change so that a determination can be made regarding my continued eligibility for this benefit.

Signature _____

Date _____

The Office of Rural Health gathers this information to verify your eligibility for a state-sponsored reduction in your professional liability premiums. The information will be shared only with the State Accident Insurance Fund (SAIF) for management of the program. No other disclosures will occur from the Oregon Office of Rural Health.