



COMPLETE THIS FORM TO GET A QUICK PREMIUM COMPARISON FOR PROFESSIONAL PODIATRIST INSURANCE

4001 Miller Road, Wilmington, DE 19802-1999 Tel: 800-365-0816 Fax: 302-764-9125 www.rockwoodinsurance.com

Name _____

Primary Office Address _____

City _____ County _____ State _____ ZIP _____

Email _____ Phone (_____) _____ Fax (_____) _____

Date of Birth _____ Date Practice Started _____

Current Policy Expiration Date _____ Retroactive Date _____

Current Policy Limits \$ _____ Current Policy Deductibles \$ _____

Insurance Company Name _____ Annual Premium Paid Last Year \$ _____

Practice Hours per Week _____

I practice as _____ Owner Employee of another DPM Associate Independent Contractor

My practice is _____ Solo Practice Partnership Corporation LLC Association Multi-Podiatrist

I employ other DPMs in my practice. Yes No If "Yes", how many are employees? _____ Independent contractors? _____

I have completed a risk management course in the past 2 years. _____ Yes No I am a member of a regional or national podiatric organization. _____ Yes No

I teach. _____ Yes No I am board certified. _____ Yes No

I am enrolled in a residency program. _____ Yes No Patient medical history is updated each visit. _____ Yes No

I have had additional medical training after my residency. _____ Yes No I use Written Informed Consent for surgical procedures. _____ Yes No

What percent of my patient load involves diabetic patients? 0-15% 16-30% 31-50% 51-70% 71-100%

The time I spend performing the following procedures is (if none, write "0"):

Non Surgical Care _____ % Soft Tissue Surgery _____ % Osseous Surgery _____ % **Must equal 100%**

If 5% or less Osseous Surgery, do I refer patients to another podiatrist for surgery? _____ Yes No

The estimated number of the following **surgeries** I perform **per year** is? (if none, write "0")

Implants/Prosthesis _____ Bunion Surgery–Non Osteotomy _____

Ankle/joint/lower leg surgery _____ Bunion Surgery–Osteotomy _____

Tendon/Tendon Transfer Surgery _____ Sport Injuries or Children (Surgery Only) _____

Loss Information—Has any professional liability claim or suit been made against you, your predecessors in business, or against any past or present partner? _____ Yes No If "Yes", please provide details on a separate sheet.

Are you aware of any circumstances that might give rise to a claim under this policy? Yes No If "Yes", please provide details on a separate sheet.

Please return via fax to 302-764-9125. For more information call 800-365-0816.