

South Carolina Medical Malpractice Association
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www.scmma.net

SC MMA
LOCUM TENENS HEALTHCARE PROVIDER APPLICATION

Assessable Policy

Instructions

1. Please answer ALL questions completely, leaving no blanks. (Use N/A if Not Applicable)
2. If you need more space for responses, continue on a separate sheet with the question noted.
3. The Locum Tenens Healthcare Provider Application must be signed and dated by the applicant.
4. **Please email the completed Locum Tenens Healthcare Provider Application, along with a copy of the applicant’s business letterhead and any other required additional information to: Teresa.Anderson@marsh.com**
5. Please contact the SCMMA Underwriting Department if you have any questions.

***Important:** No action can be taken on this application until it is complete. “Complete” means all questions have been answered, with separate explanations provided as requested. It must be signed and dated in the appropriate places, and ALL documents listed in Section A must be attached.*

A. REQUIRED ATTACHMENTS AND IMPORTANT NOTIFICATIONS:

1. Yes No Are you currently covered by a medical professional liability policy?
 1a. If “Yes”, attach a copy of **current medical professional liability insurance declarations page or a certificate of insurance** showing the type of policy form and current retroactive date.
2. Copy of **Curriculum Vitae** (CV/Resume).
3. Copy of South Carolina **Medical License**.
4. **National Practitioner Databank Report** (<http://www.npdb.hrsa.gov> or 1-800-767-6732). The evaluation date or date of issue of the NPDR may not be more than 60 days old.

***Important:** Every effort will be made to advise the applicant within 48 hours if they are eligible for Locum Tenens Coverage through the MMA. If a physician is determined to be eligible, his/her approved application will be in effect for one year. Eligible/approved physicians must submit a Locum Tenens Coverage Request Form in advance of each substitute period.*

***Important:** Written request for Locum Tenens coverage approval for a substitute healthcare provider must be made in advance using this application. Locum Tenens coverage cannot be provided on a retroactive basis if the request is made late. A MMA policy may provide up to 60 days of coverage during the policy period for duly licensed substitute healthcare provider working on behalf of the MMA physician (policyholder) on a temporary basis due to vacation, illness, or other absence.*

B. LOCUM TENENS HEALTHCARE PROVIDER APPLICATION:

7. Check if you are a: Physician Dentist/Oral Surgeon Nurse Practitioner Physician Asst.
8. Name of the applicant:
 Name: _____ SC License #: _____
9. Are you licensed in any states other than South Carolina? Yes No
 9a. If "Yes", please list states and license numbers: _____
10. Are you employed full-time or part time at any other facility? Yes No
 If "Yes":
 10a. Name of employer or professional affiliation: _____
 10b. Do you have coverage under a separate policy for this exposure? Yes No
 10c. Please provide name of carrier: _____
 10d. Limits of coverage: \$ _____ per occurrence. / \$ _____ annual aggregate
 10e. Type of coverage: Claims-made Occurrence
11. Mailing Address of Applicant:
 P.O. Box or Street: _____
 City: _____ State: _____ Zip: _____
12. a. Practice you will be providing Locum Tenens for: _____
 b. Office Telephone Number: _____ Fax Number: _____
 c. Home/Cell number: _____ d. May we contact you by fax? Yes No
13. Email Address: _____ 13a. May we contact you by email? Yes No
14. Web address of current employer or professional affiliation: _____
15. Have you ever been convicted of a State or Federal felony involving moral turpitude? Yes No
16. Has any hospital ever denied, suspended, or revoked your privileges? Yes No
17. Has your narcotics or medical license ever been suspended, restricted, revoked or voluntarily surrendered or has probation been invoked? Yes No
18. Have you ever been denied a medical license or been denied certification by a specialty board? Yes No
19. Do you have any unpaid obligations on any professional liability policies? Yes No
 19a. If "Yes" to any of questions 10 – 14 please provide a written explanation on separate sheet.
20. What is your specialty? _____
21. Are you Board Certified? Yes No
 21a. If "Yes", please provide date of certification: ____ / ____ / ____

C. AGREEMENT

By signature of this Locum Tenens Substitute Healthcare Provider Application, I agree that the statements contained herein are my agreements and representations and if coverage is extended in reliance upon the truth of such representations any willful misstatement of fact may invalidate Locum Tenens coverage through the South Carolina MMA.

 Signature of Applicant

____ / ____ / ____
 Date

The information contained in this application is privileged and confidential. It is intended only for the use of the SCMMA. If the reader of this application is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this document is strictly prohibited. If you have received this in error, please notify the South Carolina MMA immediately by telephone and return this application to the SCMMA via U.S. Postal Service. Thank you.