



2. Professional Liability Questionnaire

Name of Organization _____

Please submit 1. Nonprofit General Profile Questionnaire along with this questionnaire.

Describe professional services performed at your operation.

Does your organization need professional liability coverage?

Social Workers/Counselors Yes No

Teachers Yes No

Medical Professional Yes No

Is your current coverage on occurrence or claims-made form?

If claims-made form, please indicate the retroactive date on policy: _____

Please attach a copy of the endorsement from current or expiring policy verifying date and limits of coverage.

Total number of non-duplicated clients for all operations? _____

Have your organization, employees, volunteers or independent contractors had any professional liability allegations, claims or notifications in the past five years? Yes No

Has your organization had any allegations, claims or notifications because of actions of your medical professionals in the past five years? Yes No

Has any similar insurance for the organization, officers, employees or independent contractors ever been cancelled or non-renewed? Yes No

Please describe all Yes responses in full detail including all allegations, claims or notifications made against your organization.

Teachers Liability Questions	Number of Teachers/Aides	Number of Students
Child care, Montessori, Head Start		
Kindergarten – 8 th grade		
9 th grade through 12 th grade		
Other (i.e. developmental training)		

Medical Professional Questions

Describe detailed activities performed by your medical personnel.

Number of hours medical personnel work per week for client _____

Do you require the medical professional to hold a valid and unlimited license to practice medicine in the state, an unrestricted DEA permit, and be a Medicaid/Medicare participant? Yes No

Do you require the medical professional to provide proof of their individual medical malpractice/professional liability insurance? Yes No

If yes, minimum limits required. _____

Do you require the medical professional's policy to name the nonprofit as additional named insured? Yes No

How often are updated certificates obtained? _____

Please attach copy of each contract and proof of malpractice/professional liability (certificate of insurance or copy of declaration page) for each individual.

Do you operate any of the following? If yes, describe operations, number of beds, and number of staff for each exposure.

Medical clinic

Laboratory

Hospital or infirmary

Overnight medical services

Visiting Nurse Services

Hospice

Home Health Care Services

Other

This form has been completed by:

Name:

Title:

Date: