**Get a Premium Indication for Certified Nurse Midwife Professional Liability Insurance**

**PRACTICE PROFILE**

**Date you started practice as a nurse midwife: \_\_\_\_\_\_\_\_**

**State & County of practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please check the appropriate description of your practice:**

Owner of: Solo Practice \_\_\_\_ Group \_\_\_Birth Center

Employee of: Hospital \_\_\_\_ Group \_\_\_Birth Center

Independent Contractor of: Hospital \_\_\_ OBGYN Group

\_\_\_ Midwife Group \_\_ Birth Center

**Do you supervise others, such as RNs, LPNs or doulas?**

Circle: YES NO

**Number of hours worked per week:** \_\_\_\_\_\_\_\_

**Average number of patients seen per week:** \_\_\_\_\_\_\_\_

**List Hospitals, Birth Centers or Clinics where you hold privileges:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RISK MANAGEMENT PRACTICES**

**Do you have a written agreement with collaborating OB/GYN?**

Circle: YES NO

**Do you obtain Written Informed Consent for all patients?**

Circle: YES NO

**Are patients screened prior to delivery and determined to be low risk of complications?\***

Circle: YES NO

**Do you have procedures in place to facilitate transfer of patients who develop high risk conditions during their course of treatment with you?\***

CIRCLE: YES NO

**Do you have emergency transfer protocols in place for any delivery that takes place in a non hospital setting?**

CIRCLE: YES NO

***\**** *Patients including but not limited to those with diabetes, high blood pressure, pre-eclampsia, placenta problems, prior c-section delivery, multiple births or previous birth complications are not considered to be low risk.)*

**LOSS and DISCIPLINARY ACTION INFORMATION**

No Claims or Disciplinary Actions Ever **OR \_\_\_\_** # of Claims \_\_\_\_\_ # of Disciplinary Actions

If you have any questions about insurance for your practice, please note here.

\* ***Premium indications provided are not firm quotations and are not bindable. Terms, limits, deductibles, conditions and price may change upon receipt, review and acceptance of a completed application and supporting documentation by the company. A binding quotation will not be issued without the company’s full underwriting due diligence.***

**MIDWIFE TRAINING**

**School, City, State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Nurse Midwife Degree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**License Number(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you up to date on your CE credits? Circle:** YES NO

**Certified by AMCB?** Circle: YES NO

**Member of the ACNM? \_**Circle: \_YES \_\_NO

PRACTICE PROFILE

**Please estimate the annual number of the following procedures based on your current practice:**

Vaginal Deliveries \_\_\_\_\_\_\_\_\_\_\_\_

Scheduled Caesarian Sections \_\_\_\_\_\_\_\_\_\_\_\_

Emergency Caesarian Sections \_\_\_\_\_\_\_\_\_\_\_\_

Multiple Births \_\_\_\_\_\_\_\_\_\_\_\_

Patients transferred to hospital during labor or

post delivery \_\_\_\_\_\_\_\_\_\_\_\_

VBACs \_\_\_\_\_\_\_\_\_\_

**What percentage of your deliveries is done in each of the following locations***?*

Hospital

Birth Center

Home

Other (Describe)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CURRENT POLICY INFORMATION**

**Carrier:**

**Expiration Date:** \_\_\_\_\_\_\_\_\_\_**Retroactive Date:** \_\_\_\_\_\_\_\_\_

**Limits:**

$100,000/$300,000 $250,000/$750,000

$1 Million/$3 Million Other:

**Annual Premium: $**

**Name**

**Street**

**City County State Zip**

**( ) ( )**

**Phone Fax**

**Email**