



**WESTERN WORLD
INSURANCE COMPANY**

**APPLICATION
FOR
NURSES PROFESSIONAL LIABILITY**

1. Name of Applicant _____
 Street Address _____
 City _____ State _____ Zip _____

2. Degree of Certification: CNP RN LPN PA
 Year Conferred _____ Institution _____
 If CNP or PA, describe duties* _____

3. Are you an: Employee Independent Contractor

4. Indicate the percent of time spent in the following work locations:
 _____ % Administrative office _____ % Outpatient clinic _____ % Classroom
 _____ % Laboratory _____ % Hospital ER _____ % Patient's Home
 _____ % Professional office _____ % Nursing Home _____ % OR
 _____ % Hospital Ward _____ % Abortion Clinic _____ % Other _____

5. Do you administer any anesthesia? Yes No

6. Do you administer IV or Chemotherapy? Yes No
 If so, describe any special training.* _____

7. Do you provide OB/GYN or Midwife services? Yes No
 If yes, describe.* _____

8. Has your nursing license ever been suspended or revoked? Yes No
 If yes, give details.* _____

9. Prior insurance carrier and loss history last 5 years. If no prior insurance, check here.

Year	Insurance Company	Policy Number	Loss paid/ reserved	Description

10. Is the applicant, aware of any circumstances that may result in a claim? Yes No
 If yes, provide details.* _____

11. LIMITS OF INSURANCE REQUESTED:
 \$ _____ Each occurrence limit
 \$ _____ General Aggregate limit

Policy effective date: From _____ To _____

* If more space needed, use back of form.

Applicant's Signature: _____ Date: _____

Title: _____ Producing Agent: _____