Jackson Memorial Hospital

Lexington Insurance Company

Residency / Preceptorship Professional Liability Program Application

Please attach a copy of your resume & FL Medical License

1. If my application is approved, make coverage effective at 12:01 a.m. on _____/____/_____and ending on _____/___/____ midnight. *(this coverage will protect you exclusively during preceptorship)*

2. Name _____ MD
   First Middle Last

3. Date of Birth: _____Place of Birth: _____ ☐ Male ☐ Female

4. Social Security Number: _____

5. Florida Medical License: _____ Status:._____

6. Medical School of Graduation: _____ If a foreign medical school graduate. do you have an ESFMG Certificate or a Fifth Pathway Certificate? ☐ Yes ☐ No If Yes, Indicate which certificate was obtained and your certification.

7 Name of Institution where completed your medical internship:_____

8. Name of Sponsoring Institution for Preceptorship: _____

9. Location of Preceptorship:

_____
Number Street City State Zip

10. Description of Preceptorship: _____
(Attached Letter if necessary)

_____

_____

_____

_____

11. Have you **ever** been involved in a malpractice claim or suit, with an incident date. report date? If, **Yes**. submit a separate form for each case in the last five (5) years (Page 2). ☐ YES ☐ NO

Please see page 2 for claim summary and application signature (**Required**)

Fraud Statement

Section 817.234(1)(b), Florida Statutes

This section requires insurers to include a specified fraud statement on applications as well as claim forms.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information, is guilty *of* a felony of the third degree

CLAIM INFORMATION

1. Name of patient: _____ 2. Age: _____
3. Details of allegation(s) _____
4. Date of incident: _____ 6: Reported Date: _____
5. Insurance carrier: _____
6. Name of your defense attorney: _____
7. Other defendants: _____
8. Present status of claim **(check applicable. answer and fill in amounts where needed)**

☐ Precautionary/Incident report only ☐ Open Case Current Case Reserve $.

☐ Suit threatened, no action taken

☐ Dropped by claimant

☐ Summary judgment in your favor ☐ Case Settled

Date Paid: _____ Amount Paid $ _____

☐ Court trial in your favor mm/dd/yy

9. Location of incident. _____
10. Condition and diagnosis at time of incident: _____
11. Dates and description f treatment rendered: _____
12. Condition of patient subsequent to treatment (and DATES OF FOLLOW-UP TREATMENT) _____

_____

I HEREBY DECLARE THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____MD._____

Date Signature of Applicant

Please return to: C/O GME Office
Director of Risk Management