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: _____