Robert E. Burke, CPA
Managing Director

Research RFMH for Mental Hygiene, Inc.
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Professional Liability Insurance Form

All Medical Doctor's (Doctor of Medicine, Doctor of Osteopathic Medicine, or the equivalent) working for the Research Foundation for Mental Hygiene, Inc. (RFMH) are required to complete this questionnaire to assist us in assessing the professional liability coverage required to ensure that you and RFMH are adequately covered while you are rendering services within the scope of your duties as an RFMH employee.

You are required to complete, sign and return this form to your local RFMH Personnel Office **before** you are placed on the RFMH's payroll. Submission of an incomplete form may delay your appointment. You must also provide updated information and annual re-submissions as described on page four of this document. Failure to do so in a timely manner may result in your removal from the payroll.

Please be sure to print clearly and answer all questions. If you prefer, you may complete this questionnaire on line by going to our website at http://corporate.rfmh.org/human_resources/index.asp?page=forms and selecting the Professional Liability Insurance form.

PLEASE PRINT CLEARLY OR TYPE ALL OF YOUR ANSWERS.

Name: _____ _____ _____
(First) (Middle Initial) (Last)

Telephone number where you may be reached: (____) _____

E-mail address: _____

Work location: _____

RFMH account (s) you will be paid from for the next year: _____

Principal Investigator(s) for the account(s):_____

What is your Medical Specialty? _____

Board Eligible Yes or No	***Board Certified Yes or No***	***Specialty(s)***	***Date Obtained***

List current Medical license(s), State(s) and license(s) number(s):

State _____ License Number _____ Date _____

State _____ License Number _____ Date _____

OR Are you an unlicensed M.D.? Yes ( )

Number of hours ***per week*** you will be working for RFMH: _____

The following questions are specific to your employment by RFMH only.

1. In your employment with RFMH will you have contact with research subjects and/or patients? Yes ( ) No ( )

   If yes, will you be prescribing or administering medications? Yes ( ) No ( )

   If yes, what is the average number of research subjects and/or patients you will be prescribing or administering medications to on a weekly basis? _____.

In the space below describe the classes of medications you will be prescribing or administering to research subjects and/or patients.

2. Will you be prescribing or administering controlled substances to research subjects and/or patients? Yes ( ) No ( )

   If yes, what is the average number of research subjects and/or patients you will be prescribing and/or administering controlled substances to on a weekly basis? _____

   In the space below please indicate the controlled substances and their Schedule numbers.

Name of Controlled Substance	***Schedule Number***

3. Will you be conducting any invasive procedures; including blood draws, and/or any procedures that involve greater than minimal risk? Yes ( ) No ( )

   In the space below, please describe the types of invasive and/or greater than minimal risk procedures you will be performing along with the average number of research subjects and/or patients that will be involved on a weekly basis.

Type of Procedure	***Average Number of Subjects and/or Patients Per Week***

4. Please describe **your RFMH job duties** as they relate to interactions with research subjects and/or patients. In this description also indicate your role(s), e.g. Principal Investigator, person responsible for medical screening of potential research subjects, etc. Be sure to provide sufficient detail to supplement the information provided in questions 1- 3 above, so that we can understand the **nature** and **frequency** of your interactions with research subjects and/or patients.

5. Are all activities described in question 4 conducted as part of IRB approved protocols: Yes ( ) No ( )

   If No, please identify those activities that are outside the scope of IRB approved protocols:

6. Have you ever been debarred, disqualified, or banned from conducting clinical trials or are you under investigation by any regulatory authority for debarment, disqualification or any similar regulatory action? Yes ( ) No ( )

   If yes, in the space below please provide the details.

7. Have you ever been the subject of a report to the National Practitioner Data Bank? Yes ( ) No ( )

   If yes, in the space below please provide a brief description of the report including the date it was filed and the nature of the report, e.g. medical malpractice claim payment.

I agree to notify my local RFMH Human Resource Office if my duties with respect to the nature and frequency of my interactions with research subjects and/or patients change during the course of employment with the RFMH. Changes that involve a significant increase in the extent of contact with research subjects and /or patients, those that involve a significant increase in the level of risk associated with the contact, and those where the nature of the interactions is significantly different, must be reported prior to assuming those changed duties for the RFMH. All other changes must be reported promptly.

I understand that changes in these interactions with research subjects and/or patients may affect the insurance coverage required to protect me and the RFMH. Please use the enabled digital signature or print and sign.

Signature: _____ Date: _____

Note: Every January RFMH's Central Office Human Resource Department will ask you to submit a new Professional Liability form to update the information you have provided. Failure to submit a complete and timely form may result in termination from the payroll until the fully completed form is received and reviewed by the Central Office.

This form is also available in fillable format on the Research RFMH for Mental Hygiene's website at http://corporate.rfmh.org/human_resources/index.asp?page=forms

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The section on the following page will be completed by your local HR office and Central Office.

To be completed by the local RFMH HR Department and Central Office:

Action	***Signature***	***Date***
Reviewed by the location HR Director		
Review by Deputy Managing Director		
Entry made on insurance spreadsheet		
Institute notified of approval to hire		