REGISTRATION OF CHARITABLE HEALTH CARE PROVIDERS

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EFFECTIVE JULY 1, 1998 – JUNE 30, 1999

CHARITABLE HEALTH CARE PROVIDER INFORMATION:

(Name) _____

(Address) _____

(City, State & ZIP) _____

(Phone,Office) ***(Home)*** _____

(License #) _____

IF A CLINIC POLICY, PLEASE LIST ALL LICENSED PROVIDERS RENDERING MEDICAL CARE COVERED UNDER THE POLICY:

LICENSE #	***PROVIDER***	***ADDRESS***	***STATE OR TERRITORY***

MALPRACTICE INSURANCE COMPANY

POLICY PERIOD: _____ ***POLICY NUMBER*** _____

EXPECTED NUMBER OF PATIENTS FOR THE POLICY YEAR

ARE SERVICES RENDERED THROUGH A SPONSORING ORGANIZATION <u>REGISTERED</u> WITH THE CABINET FOR HUMAN RESOURCES? YES NO

LIST THE COUNTY (S) THE PROVIDERS COVERED BY THIS POLICY WILL SERVE?

_____

WHO ARE THE INTENDED RECIPIENTS (patients) OF SERVICES RENDERED BY THIS CHARITABLE HEALTH CARE PROVIDER?

WHAT TYPE OF SERVICE WILL THIS PROVIDER RENDER? (Family Practice, Pediatrics, Internal Medicine, OB/GYN)

PROVIDER TYPE: PHYSICIAN___ NURSE PRACTITIONER___

NURSE MIDWIFE____ PHYSICIAN ASSISTANT___

OTHER *(please explain)*_____

WHAT DATES WILL THE SERVICES BE PROVIDED TO THE INTENDED RECIPIENTS?

EMPLOYMENT STATUS:

Private Practice _____

Hospital Staff _____

Fulltime Volunteer _____ ***Number of hours per week _____***

Part-time Volunteer _____ ***Number of hours per week _____***

NOTARIZED STATEMENT

I hereby acknowledge that I will adhere to all risk management loss and prevention policies and procedures of _____ Insurance Company, and do hereby affirm that this is the only medical professional liability insurance policy, which covers myself of the aforementioned facility. I acknowledge that my license or certificate has never been suspended or revoked and I will no render services outside the scope of practice authorized in my license or certificate.

Our office welcomes you as a new Charitable Healthcare Provider.

Our office does reimburse medical malpractice premiums for Charitable Clinics/Care givers i.e. M.D.'s, R.N.'s etc... as long as they are in no way compensated for their services. Any additional questions you may have regarding your registration please contact Shellie Wingate, Health Program Administrator Department for Public Health, 275 East Main Street, HS2WB Frankfort, Kentucky 40621. Phone number (502) 564-8966 (ext 4003), Email address is shellie.wingate@ky.gov, and fax number is (502) 564-0655.

When requesting the Charitable Healthcare Reimbursement you are required to submit the following: reimbursement form, cancelled check (front & back), copy of the insurance policy with the declaration pages and a copy of the registration form you received from the Department of Public Health. Our office only reimburses the premiums that have already been paid by the clinic/doctor, etc....

If our office can be of further assistance, please do not hesitate to contact

us. Sincerely,

Michael Staley
Insurance Policy Specialist II
Property & Casualty Division
Kentucky Department of
Insurance
mdstaley@ky.gov

REQUEST FOR REIMBURSEMENT

FACILITY NAME, ADDRESS & PHONE:

_____

_____

_____

_____

MAKE CHECK PAYABLE TO: _____

AMOUNT OF CHECK: _____

COMPANY INSURED BY: _____

POLICY NUMBER: _____

POLICY PERIOD: _____

Mail to: Property & Casualty Division, Kentucky Department of Insurance, P O Box 517, Frankfort, Kentucky 40602 ... Phone **(502) 564-**6046 ... Fax (502) 564-**2728**

(FOR DEPARTMENT USE ONLY) REFERENCE NUMBER: