

AMERICAN PHYSICIANS ASSURANCE CORPORATION

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Supplemental Information Form for Radiologist

Please answer all applicable questions. If necessary, please add a second page for answers that are longer than the allotted space.

1. Name: _____ 2. MD DO Other: _____
3. Policy No.: _____ (Leave blank if you do not currently have your professional liability insurance with American Physicians)

4. Is the practice a stand alone clinic or is the group contracted with a hospital?

5. Is this a solo practitioner practice? Yes No If no, how many radiologists are in the group? _____

6. If a group practice, are there any independent practitioners in the group? Yes No

If yes, please list the independent practitioner(s):

7. Is teleradiology performed in the practice? Yes No

If yes, please list physician(s) that perform teleradiology:

8. If radiologist(s) perform teleradiology, please list all the states & license # in which teleradiology is performed.

_____ Lic#	_____ Lic#
_____ Lic#	_____ Lic#
_____ Lic#	_____ Lic#

9. Do you or any radiologists in the group perform interventional or invasive radiology? Yes No

If yes, which of the following is performed?

- | | | |
|---|---|--|
| <input type="checkbox"/> Angiography | <input type="checkbox"/> Cholangiogram | <input type="checkbox"/> Recanalization of vessels |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Ductography | <input type="checkbox"/> Stent placement |
| <input type="checkbox"/> Arterial Catheterization | <input type="checkbox"/> Fistulography | <input type="checkbox"/> Thoracentesis |
| <input type="checkbox"/> Arteriography | <input type="checkbox"/> Myelography | <input type="checkbox"/> Uterine artery embolization |
| <input type="checkbox"/> Arthrography | <input type="checkbox"/> Percutaneous biopsy | <input type="checkbox"/> Venography |
| <input type="checkbox"/> Cardiac Catheterization | <input type="checkbox"/> Percutaneous procedures | <input type="checkbox"/> Vertebroplasty |
| <input type="checkbox"/> Chemoembolization | <input type="checkbox"/> Radio/Laser tumor ablation | |

10. If group practice, please list all physicians that practice interventional or invasive radiology

11. Are there separate consent forms for each invasive/interventional procedure? Yes No

12. If you or the group performs mammograms, are all mammograms over-read by a second radiologist? Yes No

13. Percent of practice devoted to mammography? _____%

14. Average workload/number of procedures per year/physician? _____

Signature: _____ Date: _____