

CONTROLLED RISK INSURANCE COMPANY, LTD.
(Grand Cayman, British West Indies)

EXTENDED PROFESSIONAL LIABILITY INSURANCE FOR MOONLIGHTING

Professional liability insurance coverage applies on behalf of physicians, dentists, and podiatrists, who are named on the *expanded coverage schedule of insureds*. The insurance described in this confirmation is subject to the terms and conditions of the policies. Limits of Liability may be subject to change effective January 1, 2008.

Limits of Liability \$5,000,000 each claim, \$10,000,000 annual aggregate each physician, dentist, and podiatrist.
Policy Number(s) CCAYM-C-GLPL-II39-2008 and excess insurance contracts.
Effective Dates July 1, 2008 to July 1, 2009

The insurance provided by the policy is hereby extended to the individual named herein to cover professional services outside the scope or course of his/her professional employment with a Named Insured or program of approved medical instruction by a Named Insured for the period July 1, 2008 to July 1, 2009.

Coverage is for (check one): PGY 3 Resident PGY 4 Resident Emergency Medicine Resident Fellow

Name of Individual _____ Social Security No.

Sponsoring Institution

The individual named above has been named on the expanded coverage schedule of insureds by the Named Insured institution checked to the right.

- | | |
|---|---|
| <input type="checkbox"/> Beth Israel Deaconess Medical Center, Inc. | <input type="checkbox"/> Judge Baker Children's Center, Inc. |
| <input type="checkbox"/> Brigham & Women's Hospital, Inc. | <input type="checkbox"/> Massachusetts Eye and Ear Infirmary |
| <input type="checkbox"/> Cambridge Health Alliance | <input type="checkbox"/> The Massachusetts General Hospital |
| <input type="checkbox"/> Charter Professional Services Corporation | <input type="checkbox"/> Massachusetts Institute of Technology |
| <input type="checkbox"/> The Children's Hospital Corporation | <input type="checkbox"/> The McLean Hospital Corporation |
| <input type="checkbox"/> Dana-Farber Cancer Institute, Inc. | <input type="checkbox"/> Mount Auburn Hospital |
| <input type="checkbox"/> Faulkner Hospital, Inc. | <input type="checkbox"/> Newton Wellesley Hospital |
| <input type="checkbox"/> Harvard Vanguard Medical Associates, Inc. | <input type="checkbox"/> President & Fellows of Harvard College |
| <input type="checkbox"/> Joslin Diabetes Center, Inc. | <input type="checkbox"/> Spaulding Rehabilitation Hospital |

Name of Institution(s) _____
where Individual will be practicing part-time _____

- Coverage as described in this confirmation terminates as respects the medical or dental Named Individual at the earliest of:
1. The date upon which the individual elects to cancel such coverage, or
 2. The date the individual is removed from the *expanded coverage schedule of insureds* maintained by the Named Insured institution issuing this confirmation, or
 3. July 1, 2009.

Individual's Coverage Dates

Coverage Begins _____ Coverage Ends _____

Emergency Room Required Certification

Coverage requires both Advanced Cardiac Life Support (ACLS) and Advanced Trauma Life Safety (ATLS) certifications.
Will the Individual be practicing part-time in an Emergency Room outside the Harvard Medical Institutional System? yes no
If "yes," state when and where Individual received certifications. PGY 3 and PGY 4 residents may **NOT** moonlight in an emergency room outside the Harvard Medical Institutional System, unless enrolled in the Harvard-affiliated Emergency Medicine Residency Program.

Date _____ Agency Granting ACLS Certification _____

Date _____ Agency Granting ATLS Certification _____

Signatures

Individual's Signature _____

Signature of Chief of Service (Approved by Named Insured) _____

Controlled Risk Insurance Company, Ltd.



Linda Haddleton
Secretary

Please review and complete the checklist on the last page of this form.



Application for Extended Professional Liability Insurance for Moonlighting

Insured Individual

Name: _____
Please print

- PGY 3 Resident
 PGY 4 Resident
 Emergency Medicine Resident
 Fellow

Evaluation Factors

Yes	No	Not Applicable
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Checklist must be completed by Insured

- | | | | | |
|-----------|---|---|--------------------------|--------------------------|
| 1 | Is there congruence between your education, training, prior experience, current program, and competence and the patient care responsibilities of the requested clinical extension(s)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | Will you be the sole physician on duty in the area(s) in which clinical extension is requested? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | If 2 answered "yes," have you ascertained whether arrangements have been made for back-up physician availability, including consultation and anesthesia and radiology services, if applicable? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | Regarding the sites for which extensions are requested, have you assessed the adequacy of the support services, the physical plant, and equipment for safe patient care? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 | Will the amount of overtime work planned adversely impact on your clinical performance in either your current program or requested clinical extension? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6 | If extension requested for emergency services, please refer to the "Guidelines for Delineation of Clinical Privileges in Emergency Medicine" developed by the American College of Emergency Physicians in 1999. These guidelines list potential clinical situations that a clinical resident or fellow might face in an unsupervised Emergency Room setting with the attendant risk exposure. Do you possess the credentials to perform special procedures that may be required at the facility where you will be practicing part-time? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7 | If extension requested for emergency services, will you also be providing some in-house services, e.g. response to cardiopulmonary arrests, insertion/replacement of lines? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8 | If 7 answered "yes," have you ascertained whether arrangements have been made for physician coverage of the emergency services in your absence on the units? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9 | If extension requested for emergency services, do you possess both current ACLS and ATLS certification? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10 | Will the clinical extension site(s) provide malpractice liability coverage for you? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11 | Do the moonlighting activities exceed the maximum number of hours per week that your hospital has approved for insureds to do work? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12 | Are you in an eligible program? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13 | Name of your supervising clinician(s) at moonlighting institution: _____ | <small>Attach additional pages if necessary</small> | | |

Signatures

Insured _____
Signature of Insured _____ Date _____

Chief of Service _____
Signature of Chief of Service _____ Date _____