

PROFESSIONAL LIABILITY QUESTIONNAIRE

Applicant's Name: _____ **Date:** _____

	Yes	No	If yes, please explain (if more room is needed, please use blank sheet)
1. While in your employment or under contract, has any person performing professional services ever been reprimanded, suspended or disciplined by any agency or governmental entity?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Do you contract with individuals to perform professional services on behalf of your organization?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Do you obtain certificates of insurance, as evidence of medical malpractice coverage carried, for employed/contracted/volunteer medical doctors? a.) What limits do you require that they carry? b.) Do you confirm that coverage extends to services that MD's perform for / on behalf of your organization?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	_____
4. Do any employees dispense medication? If yes, do you maintain a medication log?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
5. Does the pre-employment background check include: a.) Professional references? b.) Fingerprint / FBI Check? c.) State-level criminal background check? d.) Education verification	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

6. Please indicate the total number of Employees/Volunteers/Independent Contractors, which fall into the following categories below

- OR -

Please provide a separate LIST OF ALL CURRENT STAFF, whether considered a "professional" or not, with names, degrees, field of study, positions, and indicate if each is an employee, volunteer or independent contractor:

	Employees	Volunteers	Independent Contractors
Administrators			
Case Managers (Masters Degree)			
Case Managers (all other)			
Child Care Workers			
Clergy			
Counselors (Masters Degree)			
Counselors (all other)			
Dentists (DDS)			
Dental Hygienists			
Home Health/Personal Care Attendants			
Nurse - CNA			
Nurse - LPN			
Nurse - RN			
Nurse Practitioner			

Mailing Address: P.O. Box 948, Minneapolis, MN 55440-0948

Street Address: 222 South Ninth Street, Suite 2700, Minneapolis, MN 55402-3365



	Employees	Volunteers	Independent Contractors
Nutritionists / Dieticians			
Optometrists			
Paramedics / EMT's			
Pharmacists			
Psychologists (Masters or PhD's)			
Psychologists (all other)			
Physicians (MD's)			
Physicians' Assistants			
Psychiatrists (MD's)			
Residential Care Managers			
Residential Care Workers			
Social Workers (Masters' Degree)			
Social Workers (all other)			
Teachers / Teaching Assistants / Tutors			
Therapists – Occupational			
Therapists – Physical			
Therapists – Speech / Hearing			
Other Professionals			
Remaining Staff			
Total			

7. Number of CLIENT CONTACTS / CLIENT VISITS* ANNUALLY at facility, by category:			
		Drug Rehab	Mental Health Center
		Alcohol Rehab	Physical Rehab
		Individual Therapy	Occupational Rehab
		Family Therapy	Hospice
		Group Therapy	Other (describe)
*Visits are defined as the number of appointments your facility provides.			

Please complete this section for each MD (Including Psychiatrists), DDS (Dentist), NP (Nurse Practitioner), & PA (Physicians Assistant) who provides services to / on behalf of your organization:

Name	Position	Degree	Med Mal Limit	Hours/Wk	Duties