



Send, Fax or Email Applications To:

WDIA
1001 4th Ave #3800
Seattle, WA 98154
Fax: 206-269-1922
Email: megan@wsda.org

Application for Professional Liability Insurance for the Western Regional Examining Board

Please print or type. Answer all questions. Coverage can not be considered until this application is completed. If additional space is required to answer any questions, please use the REMARKS section of this application.

General Information:

This application is a formal request for professional liability insurance especially for individuals planning to take the Western Regional Examining Board. If approved, coverage is provided for the June examination and, in the event it becomes necessary, the September examination of the same year.

Name: _____ Degree _____ Date of Birth: _____ / _____ / _____
Month Day Year

Mailing Address: _____

Home #: () _____ Message #: () _____

Social Security Number: _____ / _____ / _____

EXAM DATE: Seattle, WA: _____ Portland, OR: _____

Limits: \$1,000,000 each incident/\$5,000,000 annual aggregate

1. Dental School Name: _____

Location: _____

2. Graduation Date: _____ Practice location after graduation: _____

3. If other than above, where are you currently enrolled? _____

4. Are you licensed to practice in any other state(s)? Yes No

State: _____ License Number: _____ DEA Number: _____

5. Specialty: _____

6. Are you trained in CPR? Yes No

7. Have you practiced dentistry since completion of formal training? Yes No

If "Yes," where and when? _____

(Over)

8. Has your license in any jurisdiction to practice dentistry or dispense narcotics ever been denied, revoked, suspended, or voluntarily surrendered or subject to probationary terms?
 Dental License: Yes No DEA License: Yes No
9. Will your activities during the dentist examination include any procedures other than general dentistry?
 Yes No If "Yes," please elaborate in the REMARKS section.
10. Will your activities during the dentist examination include the administering, by you, or anyone under your direct supervision, of any of the following forms of anesthesia?
- a. Local Yes No
 - b. Inhalation Yes No
 - c. Intravenous Yes No
 - d. Intramuscular Yes No
 - e. General Yes No
11. For the following questions, please fully explain any "Yes" answer on a separate sheet and attach:
- a. Have you ever been treated for alcoholism, narcotic addiction, or mental illness? Yes No
 - b. Have you ever been convicted of a felony? Yes No
 - c. Have you ever suffered from or been treated for any chronic illness or physical defect? Yes No
 - d. Have you ever had any professional liability insurance refused, cancelled, nonrenewed, or restricted? Yes No
 - e. Have any claims or suits ever been filed against you as a result of professional services? Yes No

REMARKS: _____

Applicant Insured's Representation (Please read carefully):

I hereby represent that the information contained in this application and any supplemental submission is complete and true and that no material facts which are reasonably likely to influence the judgment of NORDIC in considering this application have been omitted. I agree that this shall be the basis of the policy of insurance requested and that I will notify NORDIC of any changes contained herein.

Applicant Insured's Authorization and Release (Please read carefully):

I acknowledge that as a condition precedent to acceptance of this application and any future renewal thereof, an inquiry and investigation of my professional background, qualifications, and competence, including such other underwriting or claim matters as are deemed relevant, may be conducted by NORDIC or its duly authorized representatives. I expressly consent to any such inquiry and investigation and hereby authorize the release and exchange of information pertaining to such inquiry and investigation between any professional organizations in which I am or have been a member, their insurance consultants or agents, any hospitals at which I hold or have ever held staff privileges or have had an application for staff privileges denied, any state licensing agency, any attending or treating physicians, any prior insurance carriers, prior employers, or professional associates, and NORDIC or its duly authorized representatives. I hereby release and discharge the providers of information, the Northwest Dentists Insurance Company, its duly authorized representatives, and the members or consultants of any established peer review committees from any and all legal liabilities which might otherwise be incurred as a result of any communications, reports, disclosures, or recommendations made or any acts performed, in good faith, in connection with any inquiry or investigation initiated by the Northwest Dentists Insurance Company or its duly authorized representatives.

I understand that signature of this application does not bind the company to provide this insurance.

Applicant's Signature: _____ Date: _____

A photostatic copy of this Authorization shall be considered effective and valid as the original.