



Emergency Medicine Physician Questionnaire

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| Name of Applicant: | MMIC Policy Number: |
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1. Name the hospital(s) and/or urgent care facilities where emergency medicine services are provided:

2. Please indicate employment status and hours per month for each physician. Attach a separate sheet if necessary.

| Physician Name | Employment Status | *Hours/Month |
|----------------|---|--------------|
| | <input type="checkbox"/> Employee <input type="checkbox"/> Contractor <input type="checkbox"/> Resident <input type="checkbox"/> Locum Tenens | |
| | <input type="checkbox"/> Employee <input type="checkbox"/> Contractor <input type="checkbox"/> Resident <input type="checkbox"/> Locum Tenens | |
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| | <input type="checkbox"/> Employee <input type="checkbox"/> Contractor <input type="checkbox"/> Resident <input type="checkbox"/> Locum Tenens | |

*Hours/Month – Indicate the total number of hours per month, on average, that each individual works for the Applicant.

3. What is the percentage of physician turnover in the group? %

4. Specify the annual number of emergency room/urgent care visits?

5. Do you have a formal risk management program in place? Yes No
 If yes, please attach a copy.

6. Describe your risk management and communication activities with your contracted hospital facilities (e.g. continuity of care issues and hospital interfacing):

7. Describe your adverse outcomes policy:

8. Describe your peer review process or attach written procedures:

9. Do your physicians have admitting privileges at hospital facilities? Yes No

10. Do your physicians provide direct supervision of the allied healthcare providers employed by the facilities in which they practice? Yes No

11. Does your organization employ allied healthcare providers? Yes No
 If yes, specify number for each category?
 Physician Assistants: Nurse Practitioners: Other(describe):

Applicant Signature

Date