

**Surgical Solutions**  
**Phone (561) 347-6MUA Fax (561) 392-9707**

**Surgical Assistant/Physician Information**

Name \_\_\_\_\_  
(Last) (First) (MI)

Office Address: \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State) (Zip)

PHONE NUMBER \_\_\_\_\_ CELL: \_\_\_\_\_ FAX: \_\_\_\_\_

Tax ID# (confidential): \_\_\_\_\_ SSN: \_\_\_\_\_

ILLINOIS CHIROPRACTIC/OSTEOPATHICMEDICAL LICENSE # \_\_\_\_\_

Board Certified: YES NO IF YES PLEASE LIST BOARD \_\_\_\_\_

PROFESSIONAL LIABILITY  
CARRIER \_\_\_\_\_

COVERAGE:\$ \_\_\_\_\_ PER OCCURRENCE, PER AGGREGATE \$ \_\_\_\_\_

Have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice, within the past 10 years?

Yes No

If yes please provide a full description of the nature of the action, location, amount settled and current status.

Have you ever been denied professional liability coverage, or had such coverage cancelled or not renewed?

YES NO

**I ATTEST TO THE CORRECTNESS AND COMPLETENESS OF ALL INFORMATION FURNISHED**

Name \_\_\_\_\_

Signature \_\_\_\_\_ DATE \_\_\_\_\_

**PLEASE ATTACH COPIES OF THE FOLLOWING AND FAX TO 561-392-9707:**

- 1. CHIROPRACTIC/OSTEOPATHICMEDICAL LICENSE**
- 2. MALPRACTICE COVER SHEET**
- 3. MEDICAL/CHIROPRACTIC/OSTEOPATHIC SCHOOL DIPLOMA**
- 4. MUA CERTIFICATION**
- 5. RESUME**
- 6. STATE ID OR DRIVERS LICENSE**