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Emergency Medicine Physician Questionnaire

Name of Applicant:	MMIC Policy Number:

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
	☐ Employee ☐ Contractor ☐ Resident ☐ Locum Tenens	
	☐ Employee ☐ Contractor ☐ Resident ☐ Locum Tenens	
	☐ Employee ☐ Contractor ☐ Resident ☐ Locum Tenens	
	☐ Employee ☐ Contractor ☐ Resident ☐ Locum Tenens	
	☐ Employee ☐ Contractor ☐ Resident ☐ Locum Tenens	
	☐ Employee ☐ Contractor ☐ Resident ☐ 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 _____