PART TIME APPLICATON

REQUESTING ADJUSTED RATE FOR PART-TIME PRACTICE

NAME OF INSURED:

1. **Patient Visits:** How many patient appointments do you typically have each week?

2. **Hours Working:** List the number of hours spent related to patient care each week: (Patient care includes consultation, examination, documentation, treatment, lab time, etc.)

3. **Schedule:** List your office open hours

DAY:	SUN	MON	TUE	WED	THU	FRI	SAT
HOURS:							

4. **Time Per Visit:** About how much time do you typically spend for each patient visit? (Includes consultation, examination, documentation, treatment, lab time, etc.)?

5. **Reason:** Please provide the reason(s) you are practicing on a part-time basis:

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6. **Full Time:** Do you expect to begin practicing on a full-time basis in the future Yes No

   If Yes, please specify the anticipated date:

7. **Annual Volume:** About how many patient visits did you have last year?

CERTIFICATION: I hereby declare the above statements are true, and I have not misstated or suppressed any facts. I understand the insurance company has the right, but not the duty, to audit my books to confirm the above is true and correct. I understand that any fraudulent or intentional misrepresentation could result in my rate being increased, coverage being canceled, and/or a claim being denied. I represent that the name signed/typed below was signed/typed by the Applicant, and the Applicant agrees to be fully bound by every answer in this Application.

Signature: Date: