TEXAS MEDICAL LIABILITY TRUST

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BARIATRIC QUESTIONNAIRE FOR PROFESSIONAL LIABILITY COVERAGE

PLEASE RETURN THE QUESTIONNAIRE WITHIN 14 DAYS. **POLICY NUMBER** ____________________

(For Trust Use Only)

______________ First name ______________ Middle name ______________ Last name ______________ Office phone

1. Please list all the locations where bariatric surgeries are performed.

   ______________ Name of facility ______________ City ________ State Credentialed for: ☐ Banding ☐ Bypass

   ______________ Name of facility ______________ City ________ State Credentialed for: ☐ Banding ☐ Bypass

2. Have you completed a fellowship program in bariatric surgery? ☐ Yes ☐ No
   If no, please provide additional information:
   a. How many hours of training were completed? _________
   b. How many gastric banding procedures did you perform as: First assist surgeon: _________ Primary surgeon: _________
   c. How many gastric bypass procedures did you perform as: First assist surgeon: _________ Primary surgeon: _________

3. Have you completed any bariatric related CMEs? ☐ Yes ☐ No
   If yes, please attach documentation for the past twelve months.

4. Do you perform gastric banding procedures? If yes, how many do you perform per year? _________ ☐ Yes ☐ No

5. Do you perform gastric bypass procedures? If yes, how many do you perform per year? _________ ☐ Yes ☐ No

6. Do you perform bariatric surgery revisions? ☐ Yes ☐ No
   If yes, how many do you perform a year on: Referred patients: ________ Own patients: ________

7. Are you currently board certified in bariatric surgery? ☐ Yes ☐ No

8. Have you completed the Bariatric Surgery Center of Excellence (BSCOE) program? ☐ Yes ☐ No
   If no, do you provide the following:
   a. ☐ Health assessment ☐ Psychological assistance ☐ Staff experienced in bariatric care
      ☐ Cardiac work-up ☐ Patient support groups ☐ Appropriate equipment and instruments
      ☐ Dietary instruction ☐ Qualified call coverage ☐ Facility licensing and accreditation
      ☐ Counseling ☐ Clinical pathways and standardized operating procedures
   b. Do you utilize specific screening procedures to determine the appropriate candidates for surgery? ☐ Yes ☐ No
   c. Do you have a patient follow-up program in place to prevent, monitor and manage short-term and long-term complications? ☐ Yes ☐ No

I hereby warrant and represent that the foregoing information is true and correct. I understand and agree that this questionnaire and the statements therein become a part of the policy. I further understand and agree (1) that any policy shall be issued in reliance upon the warranties and representations made herein; (2) if this questionnaire contains any false statements, the intent to deceive will be presumed; (3) any false statement or concealment will void all coverage.

______________________________ Physician's Signature ______________________ Date