



TEXAS MEDICAL LIABILITY TRUST

P.O. Box 160140 • Austin, Texas • 78716-0140 • 800-580-8658 • 512-425-5800 • fax: 512-425-5999 • www.tmlt.org

COSMETIC/AESTHETIC 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. What percentage of your practice is dedicated to cosmetic/aesthetic procedures? %
Please advise how many years you have performed cosmetic/aesthetic procedures?

2. Please check off any of the following procedures performed and the number per year:

Table with columns: You, Staff, Procedure, # per year, You, Staff, Genital Cosmetic Surgery, # per year. Rows include Laser Skin Rejuvenation, Laser Hair Removal, Laser Scar/Tattoo Removal, Hair Restoration/Transplant, Chemical Peel, Varicose Vein Treatment, Liposuction/Sculpting/Dissolve, Permanent Makeup, Non-Surgical Facelift/Skin Tightening, Eyelid Surgery, Implants, and Other.

Is a written Informed Consent obtained from the patient prior to the procedure? Yes No

3. Do you utilize specific screening procedures to determine the appropriate candidates for surgery? Yes No

4. Do the ancillary staff who are performing aesthetic/cosmetic procedures have professional liability coverage? Yes No

If yes, please provide the name of the insurance carrier:

Limits of liability:

5. Have you or your staff completed any cosmetic/aesthetic related CMEs, training or certification? Yes No

If yes, please provide documentation for the past twelve (12) months.

6. Do you perform cosmetic/aesthetic revisions? Yes No

If yes, how many do you perform a year on: Referred patients: Own patients:

7. Was training provided by the manufacturer on the specialized equipment used to perform cosmetic/aesthetic procedures? Yes No
Please provide the name(s) of the equipment below.

**Section II – Please list the name of the location, the anesthesia provided, basic life support equipment and the website at each facility where you provide cosmetic/aesthetic services. If additional space is needed, please photocopy this form as needed.**

**Facility/Location Information**

- a. \_\_\_\_\_  
Name
- \_\_\_\_\_  Office/Clinic       Surgical Center       Hospital
- \_\_\_\_\_  You       Other Physician       Other Professional
- Supervisor Name
- \_\_\_\_\_ Supervisor Insurance Carrier      \_\_\_\_\_ Limits of liability
- b. Please indicate the type(s) of anesthesia provided.
- Oral       Intramuscular Sedation       Intravenous Sedation       General Anesthesia       Tumescant Anesthesia
- Other: \_\_\_\_\_
- \_\_\_\_\_  You       Other Physician       Other Professional
- Provider Name:
- \_\_\_\_\_ Provider Insurance Carrier      \_\_\_\_\_ Limits of liability
- c. In case of an emergency situation, please check all types of basic life support/resuscitative equipment available:
- Crash Cart       Defibrillator       ER Pharmaceutical Kit       Oxygen Mask       Pulse Oximeter
- Other: \_\_\_\_\_
- d. If you advertise or have a website related to these procedures please list it below.
- \_\_\_\_\_

**Facility/Location Information**

- a. \_\_\_\_\_  
Name
- \_\_\_\_\_  Office/Clinic       Surgical Center       Hospital
- \_\_\_\_\_  You       Other Physician       Other Professional
- Supervisor Name
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- c. In case of an emergency situation, please check all types of basic life support/resuscitative equipment available:
- Crash Cart       Defibrillator       ER Pharmaceutical Kit       Oxygen Mask       Pulse Oximeter
- Other: \_\_\_\_\_
- d. If you advertise or have a website related to these procedures please list it below.
- \_\_\_\_\_

**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 Signature

\_\_\_\_\_  
Date