



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

PAIN MANAGEMENT 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. Do you perform pain management procedures in an office/clinic setting other than your own? Yes No
If yes, please provide the name and location. _____

2. Do you perform pain management procedures in an ambulatory surgery center? Yes No
If yes, please provide the name and location. _____

3. Do you perform pain management procedures in a hospital setting? Yes No
If yes, please provide the name and location. _____

4. Have you completed a pain management fellowship program? Yes No
If no, please provide documentation of training and related CME for the last twelve months.

5. Please list the pain management procedures you perform, including the number performed each year.

Type of procedure: _____ # performed each year: _____

Type of procedure: _____ # performed each year: _____

Type of procedure: _____ # performed each year: _____

6. In case of an emergency situation, please check all types of basic life support/resuscitative equipment available in your office/clinic setting or ambulatory surgical center including, but not limited to:

Crash cart Defibrillator ER pharmaceutical kit Oxygen mask Pulse oximeter

Other equipment: _____

7. Are you and/or a member of your staff currently certified in the following?

Physician: ACLS ATLS PALS Staff: ACLS ATLS PALS

8. Do you and your staff conduct simulated emergency training on a regular basis? Yes No

9. Please list the name of the nearest hospital and its proximity to your office.

Hospital Name: _____ # of miles: _____

10. Please provide any additional information or clarification regarding your pain management practice.

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 _____