NURSE-MIDWIFE QUESTIONNAIRE FOR PROFESSIONAL LIABILITY COVERAGE

Please return the questionnaire within 14 days **Policy Number:** _____

First name: _____ Middle name: _____ Last name: _____

Maiden Name: _____ ☐ Male ☐ Female License # and State: _____

Professional email address: _____Office phone: _____

1. Are you a Certified Professional Midwife? ☐ Yes ☐ No
2. Are you associated with a hospital or freestanding birthing center? ☐ Yes ☐ No
3. Please list all the locations where the procedures will be performed.

   Facility Name: _____ City: _____ State: _____

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4. Does your practice require patients to have prenatal care with a physician? ☐ Yes ☐ No
5. Does your practice include high-risk pregnancy? ☐ Yes ☐ No
6. Do you administer medications (including homeopathic and oxygen)? ☐ Yes ☐ No
7. Are you associated with a practicing physician? ☐ Yes ☐ No
   If yes, name: _____
8. At what point in the pregnancy do you rely upon the supervision of a physician?

   _____
9. Do you have an on-call procedure? ☐ Yes ☐ No
10. What is your average patient load per week? _____#
11. What type of birthing procedures have you completed apprenticeship for? (Please also list all midwifery education training)

    _____

    _____

12. Which method(s) of natural childbirth do you practice?

_____

_____

13. How many vaginal deliveries do you perform per week?

Hospital	Vaginal: #/week _____	☐ VBAC: #/week _____
Freestanding Birthing Center	Vaginal: #/week _____	☐ VBAC: #/week _____
Home	Vaginal: #/week _____	☐ VBAC: #/week _____
Other (please describe)	_____	

14. Do you assist in the performance of c-sections as part of your practice? ☐ Yes ☐ No
    Describe your participation: _____

15. Is a written Informed Consent obtained from the patient prior to the procedure? ☐ Yes ☐ No
    (Please include a copy of the Informed Consent form)

16. In case of an emergency please check all types of basic life support/resuscitative equipment available:

    ☐ Crash Cart ☐ Defibrillator ☐ ER Pharmaceutical Kit ☐ Oxygen Mask ☐ Pulse Oximeter

    ☐ Other: _____

17. Do you have a current medical emergency plan/policy? ☐ Yes ☐ No

18. Are you current in: ☐ CPR ☐ BLS ☐ ACLS ☐ PALS

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.

Signature: _____

Printed Name: _____ Date Signed: _____