

Belle Terre Surgery Center
851 Meadows Road, Suite 212
Boca Raton, Florida 33486
Phone (561) 347-6MUA Fax (561) 392-9707
Surgical Assistant/Physician Information

NAME: _____
(Last) (First)

OFFICE ADDRESS: _____
(Street)

(City) (State)

PHONE NUMBER: _____ CELL: _____ FAX: _____

SOCIAL SECURITY NUMBER _____

(confidential)

FLORIDA CHIROPRACTIC/OSTEOPATHIC/MEDICAL LICENSE # _____

BOARD CERTIFIED: YES _____ NO _____

IF YES, PLEASE LIST BOARD _____

PROFESSIONAL LIABILITY CARRIER _____

COVERAGE: \$ _____ PER OCCURRENCE

\$ _____ PER AGGREGATE

Have there been, or are there currently pending, any malpractice claims, suits, settlements or arbitration proceedings involving your professional practice, within the past 10 years?

If yes, please provide a full description of the nature of the action, location, amount settled and current status.

Have you ever been denied professional liability coverage, or had such coverage cancelled or not renewed? YES NO

I ATTEST TO THE CORRECTNESS AND COMPLETENESS OF ALL
INFORMATION FURNISHED

PRINT NAME

SIGNATURE

PLEASE ATTACH COPIES OF THE FOLLOWING:

1. CHIROPRACTIC/OSTEOPATHIC/MEDICAL LICENSE
2. MALPRACTICE COVER SHEET CERTIFICATION