Rural Medical Practitioners Insurance Subsidy Program

Affidavit for Nurse Practitioners – **Calendar Year 2019**

Please complete the applicable sections of this form (it's fillable), save to your computer, then send as an attachment to insurancesubsidy@ohsu.edu.

You must be named individually on your policy and the premium must be calculated separately. (No shared limits).

1. Your full name (First, MI, Last): _____

2. Email: _____ Office phone: _____

3. Professional Specialty: _____ OSBN License number: _____

4. Are you employed by a licensed physician? ☐ yes ☐ no 4a. Are you certified to provide obstetric care? ☐ yes ☐ no

5. Professional liability insurance carrier name: (check one) Policy number: _____

☐ Allied World	☐ National Union Fire Insurance Company
☐ CNA – Affinity Insurance Service	☐ Physicians Insurance
☐ CNA – Oregon Medical Association	☐ Preferred Professional Insurance Company
☐ Coverys	☐ ProSelect
☐ Darwin National Assurance Company	☐ The Doctors Company
☐ MAG Mutual	☐ The Medical Protective Insurance Company

6. **CURRENT PRIMARY** practice **physical** address:

Name of Practice: _____

Street Address: _____

City: _____County: _____State: _____ Zip code: _____

Number of hours spent weekly in this location (please do not include time on call or travel time) _____hrs

a. **CURRENT SECONDARY** practice **physical** address (if applicable):

Name of Practice: _____

Street Address: _____

City: _____County: _____State: _____ Zip code: _____

Number of hours spent weekly in this location (please do not include time on call or travel time) _____hrs

b. **ADDITIONAL PRACTICE SITES?** Please list by attaching an additional sheet.

I attest that I am willing to serve Medicare and Medicaid patients in at least the same proportion to the total number of my patients as the Medicare and Medicaid populations represent to the total number of people in the rural areas of the county in which I practice. *Note: This is not applicable if you checked "yes" on item 4 above.

I hereby certify that all information supplied in this affidavit is accurate to the best of my knowledge. I understand that if my practice location or insurance carrier changes, I must notify the Office of Rural Health within 10 days of the change so that a determination can be made regarding my continued eligibility for this benefit.

Signature_____Date_____

Your typed name will serve as your signature.

The Office of Rural Health gathers this information to verify your eligibility for a state-sponsored reduction in your professional liability premiums. The information will be shared only with the Oregon Health Authority for management of the program and with your malpractice carrier. No other disclosures of this information will be made by the Oregon Office of Rural Health.