Rural Medical Practitioners Insurance Subsidy Program

Affidavit for Physicians – **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

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

2. Email: _____ Office phone: _____

3. Professional Licensure: (check one) ☐ MD ☐ DO Board of Medical Examiners License number: _____

4. Medical specialty: _____ 4a. Do you practice OB? ☐ Yes ☐ No

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

_____ Allied World
_____ CNA – Oregon Medical Association
_____ Coverys
_____ Darwin National Assurance Company
_____ MAG Mutual
_____ National Union Fire Insurance Company
_____ Physicians Insurance
_____ Preferred Professional Insurance Company
_____ ProSelect
_____ The Doctors Company
_____ 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.

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.