The University of Toledo Medical Center
Practice Location Fact Sheet

A separate Fact Sheet & Procedure Checklist must be fully completed for each location.
(Note: The Checklist is completed ONLY for physicians)

1. Practitioner's Name: ______________________________

2. Practice Location Name: ______________________________

3. Practice Location Address: ______________________________

4. Practice Location Phone: ____________________ Fax: ____________________

5. Approximately how many hours per week will be spent at this location: ____________________

6. Does UTP provide the professional liability insurance coverage at this location? If another insurer provides insurance, please provide the name of the insurance company: ______________________________	UT Physicians	☐ Yes ☐ No
7. Does or will UTP bill for the services provided at this location? If you use another billing service, please provide the name of that billing service: ______________________________	UT Physicians	☐ Yes ☐ No
8. By practicing at this location, is the **TEACHING MISSION** of UT supported? Please explain whether you teach medical students, residents/fellows and/or other students and any other teaching activities:______________________________ ______________________________	I Do Teaching At Site Medical Students Residents/Fellows Other Students (explain)	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
9. By practicing at this location, is the **RESEARCH MISSION** of UT supported (e.g. patients will be recruited for clinical/non-clinical trials, etc.)? Please explain a "yes" answer: ______________________________ ______________________________		☐ Yes ☐ No
10. By practicing at this location, is the **STRATEGIC MISSION** of UT directly supported (e.g. promoting outreach and business growth at The University of Toledo Medical Center, etc.)? Please explain a "yes" answer: ____________________ ______________________________ ______________________________		☐ Yes ☐ No
11. The service provided at this location will be [check the appropriate boxes]:	Inpatient (Hospital) Outpatient (Hospital) Outpatient (Clinic/Office)	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
12. Are the clinical services noted on the attached Practice Location Procedure Checklist form different from those you have listed on your delineation of privileges form(s) for The University of Toledo Medical Center? Please explain a "yes" answer: ______________________________ ______________________________		☐ Yes ☐ No
13. Additional comments or information about this location: ____________________ ______________________________ ______________________________		

PRACTICE LOCATION PROCEDURE CHECKLIST

(Note: The Checklist is completed ONLY for physicians)

14. Procedure Checklist for ____ (indicate location name)

(Please complete a separate procedure checklist for each practice site identified on the practice site fact sheets)

Please classify your surgical practice at this indicated location, if applicable:

☐ Cardiac
☐ Cardiovascular Disease
☐ Colon and Rectal
☐ Emergency Medicine
☐ Gastric Bypass/Bariatric Surgery
☐ General
☐ Gynecological
☐ Hand
	☐ Head and Neck
	☐ Laryngology
	☐ Neurology
	☐ Obstetrics
	  ☐ Normal Deliveries
	  ☐ C-Sections
	  ☐ Vaginal Birth after C-Section
	☐ Ophthalmology
		☐ Orthopedic
		  ☐ Spine Surgery
		  ☐ No Spine Surgery
		☐ Otology
		☐ Otorhinolaryngology
		  ☐ Including elective cosmetic procedures
		  ☐ Not including elective cosmetic procedures
		☐ Plastic
			☐ Podiatry
			☐ Rhinology
			☐ Thoracic
			______________% of Practice
			☐ Urology
			☐ Vascular
			______________% of Practice
			☐ Other
			______________

Please check any of the following procedures you want to perform, at this indicated location, under the insurance coverage you are applying for:

☐ Abortions - Elective
☐ Acupuncture
☐ Adenoidectomy
☐ Anesthesia
  ☐ Spinal
  ☐ Caudal
  ☐ General
  ☐ Local
  ☐ Other
☐ Angiography
☐ Angioplasty
☐ Appendectomy
☐ Arteriography
☐ Assist in Major Surgery
  ☐ On own patients
  ☐ On patients of others
☐ Blepharoplasty
☐ Breast Biopsy
☐ Breast Implants
  ☐ Cosmetic _____% of Practice
  ☐ Reconstructive _____% of Practice
☐ Bronchoscopy
☐ Chemonucleolysis
☐ Cholecystectomy
☐ Cholecystectomy, Laparoscopic
☐ Colonoscopy
☐ Cyrosurgery (other than external lesions)
	☐ Dermatological Surgery
	  ☐ Chemical Peels
	  ☐ Chemobrasion
	  ☐ Dermabrasion
	  ☐ Fat Transfer
	  ☐ Hair Transplants
	  ☐ Silicone Injections
	  ☐ Tumescent Liposuction
	  ☐ Other
	☐ Dermatopathology
	☐ D&C
	☐ Encephalography
	☐ Endoscopic laser therapy
	☐ Endoscopy other than Proctoscopy, Sigmoidoscopy, Coloscopy & Cystoscopy
	☐ ERCP
	☐ Exchange transfusions in newborns How many per year?________
	☐ Fluoroscopy
	☐ Fracture Reductions
	  ☐ Open
	  ☐ Closed
	☐ Gastroscopy
	☐ Hip nailings
	☐ Hyperbaric Medicine
	☐ Hysterectomies
		☐ Intensive care for newborns within a Tertiary Care Unit
		☐ Laminectomy
		☐ Laparoscopy
		☐ Laser Hair Removal
		☐ Laser Skin Resurfacing
		☐ Laser Surgery
		☐ Left Heart Catheterization
		☐ Liposuction
		☐ Lithotripsy
		☐ Lumbar Fusion
		☐ Mammography
		☐ Myelography
		☐ Norplant Insertion/Extraction
		☐ Organ Transplant
		☐ Pain Management
		  ☐ Medication Only
		  ☐ Dorsal Root Gangliotomies
		  ☐ Thoracic Sympathectomies
		  ☐ Spinal Cord Stimulators
		  ☐ Implantation/Removal Drug Infused Pumps
		  ☐ Sphenopalatine Lesioning
		  ☐ Trigeminal Lesioning
		  ☐ Cordotomies
		  ☐ Other __________________
			☐ Pediatric Screws for Spinal Surgery
			☐ Permanent Pacemaker
			☐ Polypectomy
			☐ Prenatal Care
			☐ Radiation/X-Ray Therapy
			☐ Radiopaque Dye
			☐ Scoliosis Surgery
			☐ Shock Therapy
			☐ Thyroidectomy
			☐ Tonsillectomy
			☐ Tubal ligation
			☐ Vasectomy
			☐ Weight Control ______% of Practice
			  ☐ Gastric Bubble
			  ☐ Gastric Stapling
			  ☐ Medications Prescribed:
			_____________________
			_____________________
			_____________________
			☐ Other Procedures (please list):
			_____________________
			_____________________
			_____________________

☐ **None of the above procedures are applicable to my practice at this indicated location.**

If applying for coverage for an obstetrical practice: do you have privileges to perform C-sections at this location? ☐Yes ☐ No
If "no," please provide full details of your back-up arrangements on a separate sheet.

If applicant is approved for insurance coverage, it will be his/her responsibility to notify The University of Toledo Medical Center Risk Management Department of any changes in practice specialty, including but not limited to practice location, procedures, affiliation, etc. Failure to notify The University of Toledo Medical Center Risk Management Department of such changes could require retroactive upward premium adjustment and in the event of a claim, could lead to a denial of liability coverage.