TDC Specialty Underwriters
TDC GROUP

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
(hereafter, the "Underwriter")
Servicing Address: 29 Mill Street
Unionville, CT 06085

Pain Management Procedure Questionnaire

THIS QUESTIONNAIRE IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS QUESTIONNAIRE.

Applicant Name:

Expiring Policy Number (if applicable):

1. Please check either "YES" or "NO" for every procedure to indicate whether you plan to perform any of the following procedures in your current practice:

	Yes	No
Acupuncture	☐	☐
Blocks:		
Caudal Epidural Block	☐	☐
Celiac Plexus Block	☐	☐
Cervical Epidural	☐	☐
Differential Spinal	☐	☐
Facet Joint Block:		
Cervical	☐	☐
Lumbar	☐	☐
Thoracic	☐	☐
Lumbar Epidural	☐	☐
Lumbar Sympathetic Block	☐	☐
Peripheral Nerve Block	☐	☐
Retrobulbar Block	☐	☐
Spinal Nerve Block	☐	☐
Stellate Ganglion Block	☐	☐
Sympathetic Nerve Block	☐	☐
Botox Injections	☐	☐
Cervical Discograms	☐	☐
Cervical Disk Nucleoplasty	☐	☐
Cordotomies	☐	☐
Cryoanalgesia	☐	☐
Dorsal Column Stimulator Implants/Reprogram	☐	☐
Epidural or Spinal Catheters	☐	☐
Fluoroscopy	☐	☐
Intra-Articular Block (Joint Injections)	☐	☐
Intradiscal Electrothermal Therapy	☐	☐
Intravenous Regional Anesthesia	☐	☐
Hypnosis	☐	☐
Lumbar Discograms	☐	☐
Lumbar Disk Nucleoplasty	☐	☐
Manipulation & Massage	☐	☐
Myofascial Trigger Point Injections	☐	☐
Nerve Root Injections	☐	☐
Percutaneous Discectomy	☐	☐

	Yes	No
Percutaneous Endoscopic Nerve Root Decompression	☐	☐
Peripheral Nerve Stimulation	☐	☐
Physical Therapy	☐	☐
Prolotherapy	☐	☐
If "Yes," do you use Phenol?	☐	☐
Radio Frequency Nerve Ablation	☐	☐
Rapid Detoxification	☐	☐
Sphenopalatine Lesioning	☐	☐
Spinal Infusion Implants or Removal	☐	☐
Spinal Infusion Pumps Refilling & Reprograming	☐	☐
Spinal Stimulation Implants	☐	☐
Spinal Stimulation Programing	☐	☐
Thoracic Sympathectomies	☐	☐
Trigeminal Lesioning	☐	☐
Vertebroplasty	☐	☐

2. What percentage of your practice incorporates the procedures above? _____ %

3. Where (which locations) is the insured practicing this type of surgery?

4. Please list other procedures you perform that are not listed above:

Please provide proof of training/certification with an approved anesthesia program to the procedures that you have indicated above.

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this questionnaire are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this questionnaire.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	