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

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.

For each procedure below, please provide the approximate number of times you have "Performed" or "Assisted" during the past 12 months as well as how many times you anticipate doing so during the next 12 months. If you Perform or Assist in other procedures not listed below, add each one under "Other" in each section.

A. General Procedures:	# Performed		# Assisted	
	Past Year	Next Year	Past Year	Next Year
Alternative/Holistic Medicine (explain): _____				
Angiography				
Angioplasty				
Anti-Aging Medicine (explain): _____				
Arterial Catheterization				
Arteriography				
Bronchoscopy				
CCU Care (other than admitting)				
Chelation Therapy (explain): _____				
Chemotherapy				
Colonoscopy				
Cardiac Catheterization				
Cardiac Cath – Right Heart Only				
Cryosurgery (explain): _____				
Dialysis Procedures				
Elective Cardioversion				
Endoscopy (explain): _____				
Hair Transplants				
Hypnosis				
IVP				
Laser Therapy (explain): _____				
Lymphangiography				
Myelography				
Paracentesis or Thoracentesis				
Polypectomy by Endoscopy				
Venography				
Weight reduction or Weight Control If "Yes," % of practice: _____ List methods, drugs prescribed on a separate sheet of paper				
Other (describe): _____				
☐ None of the above				

B. Gynecology Procedures	# Performed		# Assisted	
	Past Year	Next Year	Past Year	Next Year
Abortions – Your Patients				
1st Trimester				
After 12 weeks				
Therapeutic				
Elective				
Abortions – Other Patients				
1st trimester				
After 12 weeks				
Therapeutic				
Elective				
Attach list of facilities where you perform abortions.				
A&P Repair				
Cervical Cautery				
Cold Conization Cervix				
Culdocentesis				
Dilation & Curettage				
Ectopic Pregnancy				
Hysterectomy – Vaginal				
Hysterectomy – Abdominal				
Insertion of IUD				
In Vitro Fertilization If 'Yes," % of practice: _____				
Laparoscopy				
Office Gynecology				
Oophorectomy or Salpingectomy				
Tubal Ligation				
Other (describe): _____				

Do you own or operate a sperm bank for
the treatment of your patients? ☐ Yes ☐ No
the treatment of others' patients? ☐ Yes ☐ No

☐ None of the above

C. Pediatric Procedures	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Circumcisions				
Neonatology				
If "Yes," % of practice: _____				
Umbilical Catheterization & Monitoring				
Other (describe): _____				
☐ None of the above				

E. Surgical Procedures	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Adenoidectomy				
Anal Fissure				
Anal Fistulectomies				
Any surgical procedure involving cutting into or within the abdominal cavity, chest cavity, orbital cavity, spine or facial sinuses				
Any surgical procedures on malignant lesions except for diagnostic purposes				
Amputations				
Appendectomies				
Aspiration of Cyst of Breast				
BCIR				
Biopsies				
If "Yes," explain types: _____				
Cholecystectomies – Open				
Chymopapian Injections				
Hemorrhoidectomies				
Hernioplasties				
Herniorrhaphy (Inguinal or Femoral Only)				
Laparoscopic Cholecystectomies				
Mastectomy				
Mastoidectomy				
Minor Office Surgery				
Myringotomy				
Nasal Polypectomy				
Operations within the middle or inner ear				
Organ Transplants				
If "Yes," explain: _____				
Otorhinolaryngology				
Peripheral Nerve Surgery				
Prostatectomy				
Reconstructive Vascular Surgery, Thromboembolectomy and/or Thrombectomy of the arteries or veins				
Repair of laceration not involving nerve or tendon				
Submucous Nasal Resections				
Surgical treatment of cysts, superficial abscesses, minor traumatic wound & superficial biopsies				
Surgical Weight Reduction				
Thyroidectomy				
Tonsillectomy				
Vein Stripping				
Other (describe): _____				
☐ None of the above				

D. Obstetrical Procedures	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Amniocentesis – 3rd Trimester Only				
Amniocentesis – 1st or 2nd Trimester				
Breech Delivery				
Cesarean Sections				
Episiotomy				
Low Forceps				
Managing Toxemia				
Mid Forceps				
Normal Deliveries				
Prenatal Care				
Home Deliveries				
Other Non-Hospital Deliveries (explain): _____				
VBAC				
Other (describe): _____				

F. Urological Procedures	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Any cutting into or on the kidney, ureter or bladder				
Aspiration of Hydrocele				
Circumcisions				
Orchiectomy				
Phalloplasty (including transecting the suspensory ligament of the penis and/or subcutaneous fat injection)				
Prosthetic Implants				
Sex Change Surgery				
Treatment of Torsion of the Testicle				
Vasectomy				
Other (describe): _____				
☐ None of the above				

G. Anesthesia Procedures:	# Performed Past Year	# Performed Next Year	# Assisted Past Year	# Assisted Next Year
Acupuncture				
If "Yes," for anesthesia?			☐ Yes	☐ No
Caudal				
Digital Block				
General				
Intravenous Anesthesia				
Intravenous Analgesia				
Nitrous Oxide				
Obstetrical Anesthesia				
Pain Blocks				
Pain Management				
If "Yes," please complete a Pain Management Questionnaire				
Peripheral Nerve Block				
Spinal Anesthesia				
Other (describe): _____				

If "Yes" for any Anesthesia type, check locations where performed:
☐ Hospital ☐ Surgicenter ☐ Non-hospital facility

H. Plastic & Cosmetic Procedures:	# Performed		# Assisted	
	Past Year	Next Year	Past Year	Next Year
Autologous Fat Injection				
Blepharoplasty (cosmetic)				
Botox Injections				
If "Yes," location, by whom and what procedure/purpose? _____ _____				
Breast Reduction				
Breast Enhancement – Silicone				
Breast Enhancement – Saline				
Breast Enhancement – Trans-Umbilical				
Chemical Peels				
Collagen Injections				
Coronal Lift				
Dermabrasion				
Hair transplants or suturing of hair pieces				
Injection Treatment of Varicose Veins				
Laser Therapy (explain): _____				
Laser vaginal rejuvenation (includes cosmetic and /or plastic surgery procedures performed on the vagina and associated structures. This includes, but is not limited to vaginoplasty, labiaplasty, laser and non-laser rejuvenation procedures).				
Other Surgical Procedures (explain): _____				
Liposuction – under 3500 ccs				
Liposuction - 3500 ccs or more				
Phalloplasty – including transecting the suspensory ligament of the penis and/or subcutaneous fat injection				
Rhinoplasty				
Silicone Implants (types and where) _____ _____				
Silicone Injections				
Other (describe): _____				
☐None of the above				

Do you perform Anesthesia for any Bariatric Surgery Procedures? ☐Yes ☐No

Do you employ any inhalation therapists? ☐Yes ☐No

Have you assumed supervisory duties over:
Nurse Anesthetists? ☐Yes ☐No
Inhalation Therapists? ☐Yes ☐No

☐None of the above

I. Orthopedic & Neurosurgical Procedures:	# Performed		# Assisted	
	Past Year	Next Year	Past Year	Next Year
Any operative orthopedics				
Arthroscopy or Arthrography				
Injection of Bursa				
Joint Implants				
Neuro Implant Surgery for Pain				
Open Reduction of Fractures				
Prolotherapy				
If "Yes," do you use Phenol? ☐Yes ☐No				
Repair of Extensor Tendon				
Repair of Flexor Tendon				
Spinal Surgery				
Anterior Cervical Discectomies				
Cervical Laminectomies				
Pedicle Screw				
Scoliosis Surgery				
Stereotactic Neurosurgery				
Other (describe): _____				
☐None of the above				

J. Ophthalmology Procedures:	# Performed		# Assisted	
	Past Year	Next Year	Past Year	Next Year
Automated Lamellar Keratotomy				
Blepharoplasty (Cosmetic)				
Blepharoplasty (Functional)				
Cataract Surgery				
Chalazion Excision from Eyelids				
Corneal Transplants				
Enucleation				
Hexagonal Keratotomy (HK)				
Intraocular Lens Implant				
Iridectomy				
LASIK				
Lid-Repair – Ectropion & Entropion				
Photo-Refractive Keratotomy (PRK)				
Pterygium Excision				
Refraction's				
If "Yes," what type? _____				
Removal of Eyelid Lesion				
Retinal Detachments				
Trabeculectomy				
Treatment of Eye Infection				
Other (describe): _____				
☐None of the 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	