

## Neurosurgery Supplemental 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. What is your Subspecialty?

	<u>As Surgeon</u>		<u>As Assistant</u>	
	Yes	No	Yes	No
(a) Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Cerebrovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Stereotactic & Functional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Spine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Pediatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Peripheral Nerves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) Tumors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) Endovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) Skull Base	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) Other (please specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Indicate below any other procedures that you perform which are commonly considered to be surgery:

	<u>As Surgeon</u>		<u>As Assistant</u>	
	Yes	No	Yes	No
(a) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. If you perform spinal surgery, describe special training or experience:

Please answer "Yes" or "No" as to whether you perform or desire to perform the following procedures. Additionally, please include the estimated number of times you have performed each procedure in the past 12 months as well as how many times you anticipate performing each procedure in the next 12 months.

	As Surgeon				As Assistant			
	Yes	No	# in past 12 mos	# in next 12 mos	Yes	No	# in past 12 mos	# in next 12 mos
Acoustic Tumor Removal	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Aneurysm Clipping	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Arteriovenous Malformation Removal	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Anterior Cervical Discectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Brachial Plexus Exploration	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Brain Tumor (Intrinsic) Removal	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Carotid Endarterectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Carpal Tunnel Release	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cervical Discectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cervical Stabilization Posterior	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Craniofacial Reconstruction	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Craniosynostectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Craniotomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Deep Brain Stimulator	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Epidural Hematoma Evacuation	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Foraminotomy - Cervical	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Foraminotomy - Lumbar	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Gamma Knife	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Glioma Resection	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Joint Implants	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Laminectomy - Cervical	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Laminectomy - Lumbar	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lumbar Fusion	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lumbar Discectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lumbar Puncture	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lumboperitoneal Shunt Insertion	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Meningioma Removal	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Microvascular Decompression	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Morphine Pump Insertion	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Myelomeningocele Closure	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Neck Exposure	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Neuro Implant Surgery for Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pallidotomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pedicle Screws - Insertion	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pedicle Screws - Removal	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Posterior Fossa Decompression	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Prolotherapy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Scoliosis Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Spinal Fusion	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Stereotactic Neurosurgery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Subdural Hematoma Evacuation - Acute	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Subdural Hematoma Evacuation - Chronic	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Suboccipital Craniectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Sural Nerve Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Temporal Lobectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Transsphenoidal Craniotomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

	As Surgeon				As Assistant			
	Yes	No	# in past 12 Mo's	# in next 12 mo's	Yes	No	# in past 12 Mo's	# in next 12 mo's
Vagal Nerve Stimulator Insertion	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ventriculoperitoneal Shunt Insertion	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Ventriculoperitoneal Shunt Revision	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Vertebroplasty	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

**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	_____