

**Purpose:** This form serves as a formal request for outside activities by dentists of Permanente Dental Associates, PC. Please complete this form, obtain your Professional Director's approval, and forward to the next level for approval. Dentists will be notified of status.

Name of applicant:	Dental Office:	Phone ext:
Specialty:	Years in practice:	Years with PDA:
License(s):	Professional Director (PD):	PD Phone Extension:

### STEP I

#### Description of Outside Activities

What is the nature of the activity, course title, article, or research topic? \_\_\_\_\_

Who is the sponsoring organization, instructor, or publication? \_\_\_\_\_

Address/ location of sponsoring organization or where care will be provided: \_\_\_\_\_

Contact Person: \_\_\_\_\_  
Name Email/Phone

Single Event: \_\_\_\_\_  Recurring or Continuous: \_\_\_\_\_  
Date Schedule or Duration

1. Will you receive cash or other remuneration for this activity? No  Yes  \$ \_\_\_\_\_
2. Will you be volunteering your services? No  Yes
3. Will you be providing patient care out of the country? No  Yes

### STEP II: Choose One

- |   |  |
|---|--|
| <input type="checkbox"/> <b>Volunteer Activities Providing Patient Care</b> (Complete Section <b>A</b> )<br><input type="checkbox"/> <b>Outside Continued Education Requiring Patient Treatment</b> (Complete Sections <b>B &amp; C</b> ) | <input type="checkbox"/> <b>Publication</b><br><input type="checkbox"/> <b>Research (non-DPBRN)</b><br><input type="checkbox"/> <b>Speaking</b><br><input type="checkbox"/> <b>Other</b> _____ |
|---|--|

#### A. For Volunteer Activities Providing Patient Care

- |  |  |
|--|--|
| Is this organization tax-exempt?   | No <input type="checkbox"/> Yes <input type="checkbox"/> |
| Does the agency for which you are offering your services offer professional liability insurance? | No <input type="checkbox"/> Yes <input type="checkbox"/> |
| I am requesting an extension of liability coverage.  | No <input type="checkbox"/> Yes <input type="checkbox"/> |
| I am securing individual professional liability coverage. <b>(See Section C.)</b>                | No <input type="checkbox"/> Yes <input type="checkbox"/> |

#### B. For Outside Continued Education Requiring Patient Treatment

For courses, provide syllabus or list procedures to be done, if available: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What potential follow up care may be needed by patient after class is completed? \_\_\_\_\_

\_\_\_\_\_

**C. For Outside Continued Education Requiring Patient Treatment**

**Treatment of non-KPHP Patients Liability Coverage**

PDA dentists who participate in any educational activity involving treatment of non-KPHP patients must obtain professional liability coverage as specified in PDA's policy and is subject to approval by PDA's Board of Directors and KPHPNW's Medical-Legal Director. Please indicate the coverage you will obtain:

I have secured individual professional liability coverage through a third party insurer in the amount of \$1,000,000 per occurrence, and \$3,000,000 aggregate and shall provide for a tail coverage.

*Proof of Liability Coverage and Proof of Payment must accompany application for review by Board of Directors.*

**Proof of Sponsor Liability Coverage enclosed:**                     Yes    No  
**Proof of Individual Liability Coverage enclosed:**                     Yes    No

Applicant signature: \_\_\_\_\_ Date: \_\_\_\_\_

**STEP III**

**Applicant Signature**

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

**STEP IV**

**Professional Director (PD) Approval**

*I support this Outside Activity as described in this application:*     **Approved**    **Denied**

**Professional Director** (print name): \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**\* Forward to Peer Review for approval**

**Peer Review Approval**

*I support this Outside Activity as described in this application:*     **Approved**    **Denied**

For **Peer Review** (print name): \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**\* Forward to Executive Assistant for Board of Directors approval**

**PDA Board of Directors Approval**

*I support this Outside Activity as described in this application:*     **Approved**    **Denied**

For **PDA Board of Directors** (print name): \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**\* Forward to KPHPNW Medical Legal for approval**

**Final Approval**

**KPHPNW Medical Legal**     **Approved**    **Denied**

For **Medical Legal** (print name): \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

NOTE: Kaiser Foundation Health Plan of the Northwest usually purchases excess insurance for claims which exceed a certain limit. An approved application for extension of professional liability will not automatically obligate the excess carrier to pay for claims related to volunteer activities. The excess insurance policy itself will govern whether or not the excess insurance carrier is obligated to pay a claim. The evaluation by Regional Counsel as to the availability of excess insurance is an opinion only and cannot function as an amendment to the insurance policy in effect at the time.