Rockbridge Underwriting, An RLI Company
3700 Buffalo Speedway, Suite 300
Houston, TX 77098
(713) 874-8800

Recovering Physicians Supplemental Application

Name: _____

PART I. MONITORED AFTERCARE PROGRAM

Provide the following information about your monitored Aftercare Program:

Name: _____ Street: _____

City: _____ State: _____ Zip Code: _____

Telephone: ( ) _____ Director: _____ Date: _____

Monitoring Physician(s): _____

Check all that apply:

1) Participant (or successful Completion) ____ Yes ____ No
2) With random drug screening ____ Yes ____ No

PART II. 12-STEP ATTENDENCE

Check most appropriate one that best represents your 12-step meeting attendance:

____ None ____ 1-2 per week ____ 3-4 per week ____ 5 or more per week

PART III. CURRENT LENGTH OF SOBRIETY

Check the one that states your current length of sobriety:

____ Less than 1 year ____ 1-2 years ____ 2-3 years
____ 3-5 years ____ More than 5 years

PART IV. CHEMICAL DEPENDENCY TREATMENT WITH Successful Completion of Full Treatment Program

Check the appropriate one that describes your chemical dependency treatment:

____ None or Non-Completion ____ Outpatient ____ Inpatient less than 28 days
____ Inpatient 28-35 days ____ Extended 36-120 days ____ Extended more than 120 days

PART V. RELAPSE(S)

Check most appropriate one that best describes your experience regarding relapse(s):

____ None ____ Yes If "yes," please check the one that applies below:

Number and type of relapse(s)

____ One (brief, no consequences)
____ More than two or severe consequences (legal, criminal, medical staff, DEA, license)

Explain in detail under Section XIII.

PART VI. POST-RELAPSE(S) TREATMENT(S)

Provide the following information about your treatment(s):

Name: _____ Street: _____

City: _____ State: _____ Zip Code: _____

Telephone: ( ) _____ Director: _____ Date: _____

Monitoring Physician(s): _____

Check most appropriate that best describes your post-relapse(s) treatment(s):

____ Extended more than 28 days ____ Brief-less than 28 days or outpatient ____ None

PART VII. WORK STATUS/SETTING

Check most appropriate one that best describes your work status/settings:

____ Resident ____ Practice ____ Solo ____ Group

____ Institutional (HMO, Teaching, Government, Large Group)

PART VIII. FAMILY DISCORD

Check appropriate statement below:

Family Discord ____ Yes ____ No, If "yes," check the ones that applies below:

____ Marital Strife

____ Significant problems with children (discipline, medical/psychiatric illness, school, criminal, legal)

____ Recent ____ Divorce ____ Separation ____ Widowed (within 12 months)

Please explain in detail under Section XIII. Use a separate sheet if necessary.

PART IX. AGE

Check the one that applies:

____ Less than 35 ____ 35-55 ____ 56-65 ____ More than 65

PART X. MEDICAL SPECIALTY

Check the one that applies:

____ Anesthesia ____ Emergency Medicine ____ Family/General Practice ____ Psychiatry

____ Dermatology ____ Allergy ____ Pathology ____ Radiology

____ Pediatrics ____ Occupational Medicine ____ Rehabilitation Medicine ____ All Others

PART XI. DRUG OF CHOICE

Check all that apply:

____ Cocaine ____ IV Opiates/Narcotics ____ Amphetamines

____ Alcohol ____ All Others

PART XII. HEALTH CONCERNS

Check most appropriate one that best describes your current health status:

____ No Concerns ____ 1-2 Concerns ____ More than 2 Concerns*

*Identify concerns

____ Smoking

____ Recent Surgery – Type _____ Date(s) _____

____ Chronic pain (headaches, back pain, etc.) _____

____ Conditions requiring treatment with mood altering medications. _____

Explain in detail under Section XIII. Use a separate sheet if necessary.

PART XIII. DETAILED INFORMATION

Please use this section for explanations requested above. Use additional sheets if necessary.

This document forms a part of the Rockbridge Underwriting application and all release and warranties attached to the application apply to this supplement as well.

Name (Typed or Printed)

Signature

Date