

Part-Time Application

Name Insured: _____

Effective date of change: _____

1. List all locations where you work.

	Street	City	County	State	Zip	Phone #
(1)	_____	_____	_____	_____	_____	_____
(2)	_____	_____	_____	_____	_____	_____
(3)	_____	_____	_____	_____	_____	_____
(4)	_____	_____	_____	_____	_____	_____

2. Please indicate total hours per week and month devoted to the following activities at each office location:

	Loc. (1)		Loc. (2)		Loc. (3)		Loc. (4)	
	Wk	Mo	Wk	Mo	Wk	Mo	Wk	Mo
a. Actual patient care including recordkeeping and hospital rounds								
b. Office hours								
c. Administrative duties								
d. Surgeries and assists								
e. House calls and nursing home visits								
f. Utilization review								
g. Total practice hours								

3. How long do you anticipate practicing on a part-time basis? _____

4. Do you have a position to which no coverage is required with NJ PURE? If so, please provide us with the name of the insurer: _____

Signature of Applicant: _____ Date: _____

Part-time rate is subject to Company approval.

All questions must be answered for part-time rate to be considered.