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Telemedicine Supplemental Questionnaire

Applicant Name: _____ Policy # _____

1. Do you provide telemedicine services? ☐ Yes ☐ No

2. Are you providing telemedicine services outside the state where your practice is located? ☐ Yes ☐ No

   Note: If you answered "No" to questions 1 or 2 above, there is no need to complete the rest of this questionnaire. Just sign, date and return the form. If you answered "Yes" to either question, please fully complete the remainder of this questionnaire.

3. Please provide the list of states from which you receive films and the percentage from each state. Please provide information on any International exposure.

☐ AL ____%	☐ HI ____%	☐ MA ____%	☐ NM ____%	☐ SD ____%
☐ AK ____%	☐ ID ____%	☐ MI ____%	☐ NY ____%	☐ TN ____%
☐ AZ ____%	☐ IL ____%	☐ MN ____%	☐ NC ____%	☐ TX ____%
☐ AR ____%	☐ IN ____%	☐ MS ____%	☐ ND ____%	☐ UT ____%
☐ CA ____%	☐ IA ____%	☐ MO ____%	☐ OH ____%	☐ VT ____%
☐ CO ____%	☐ KS ____%	☐ MT ____%	☐ OK ____%	☐ VA ____%
☐ CT ____%	☐ KY ____%	☐ NE ____%	☐ OR ____%	☐ WA ____%
☐ DE ____%	☐ LA ____%	☐ NV ____%	☐ PA ____%	☐ WV ____%
☐ FL ____%	☐ ME ____%	☐ NH ____%	☐ RI ____%	☐ WI ____%
☐ GA ____%	☐ MD ____%	☐ NJ ____%	☐ SC ____%	☐ WY ____%

☐ Other Countries – Please List: _____

4. What percentage of your total practice is devoted to telemedicine? _____ %

5. Are you a member of the American Telemedicine Association? ☐ Yes ☐ No

6. Do you follow the core clinical guidelines of the American Telemedicine Association? ☐ Yes ☐ No

7. Do you follow the specific guidelines of the American Telemedicine Association for your specialty?
   ☐ Yes ☐ No

Applicant Signature: _____ Date Signed: _____

Print Name / Title: _____

E-mail: _____

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