PROFESSIONAL LIABILITY APPLICATION FOR AMBULANCE SERVICES

Instructions: Answer all questions; applicant's name must include the names of all businesses and locations for which coverage is desired; attach a separate sheet if necessary. If an answer is none, state none. If the answer is not applicable, state (N/A). If the space provided is insufficient to fully answer the question, please attach a separate sheet.

Please type or print in ink.

PART I. GENERAL INFORMATION

1. Applicant Name:______________________________

2. Mailing Address:______________________________
____

3. Location Address(es):______________________________
____

4. County (parish) of Each Location:______________________________
____

5. Person to Contact for Survey: Name:______________ Title:______________

6. Date Established:______________________________

7. The applicant is:
[ ] Corporation
[ ] Employee (W-2)
[ ] Independent Contractor (1099)
[ ] Partnership
[ ] Sole Practitioner
[ ] Sole Proprietorship
[ ] Student
[ ] Other; Describe: ______________

8. Entity is: [ ] For Profit [ ] Non-Profit
Describe source of funds:______________________________

9. If an individual, what is your profession? ______________ as [ ] Employee [ ] Student
How many years have you been practicing?______________________________
What is you specialization?______________________________

10. Name, address and type of operation of employer, or school, if student:______________
____
____
____

11. Is your employer/employment by or through a registry or temporary employment Agency? [ ] Yes [ ] No

12. Total premises square footage occupied by applicant: ____________________

13. List memberships in professional organizations: ____________________

____

14. Is the applicant eligible for certification or accreditation? [ ] Yes [ ] No

If yes, is applicant certified and/or accredited? [ ] Yes [ ] No

If no, explain the reason: ____________________

____

____

PART II. EXPOSURES

1. Annual Gross Receipts or Budget: Estimated Next 12 Months: $____________________

Last 12 Months: $____________________

2. Service is licensed as: ____________________

3. Describe the nature of insured's operation including types of services rendered and activities conducted:

____

____

____

4. Type of Service: (check where applicable)

[ ] Private (proprietary)

[ ] Rescue Squad

[ ] Chair Car (invalid coach)

[ ] Public Service

[ ] First Responder

[ ] City Owned & Operated

[ ] Fire Department

[ ] County Owned & Operated

[ ] Hospital Based

[ ] Other, Describe: ____________________

5. Total number of emergency runs: __________ last year; estimated: __________ next year

6. Total number of scheduled patient transport (non-emergency) runs: __________ last year; estimated: __________ next year

7. Radius of operations: ____________________

8. Number patient encounters at special events (if any): __________ (see question 13)

9. Total number of ambulances at each location per shift: ____________________

10. Are ambulances equipped with cardiac telemetry? [ ] Yes [ ] No

If yes, to what command center? ____________________

Who provides medical orders? ____________________

11. Does your service provide air or watercraft ambulance services? [ ] Yes [ ] No

If yes, please describe: ____________________

12. Does your service provide water rescue services? [ ] Yes [ ] No

If yes, please describe: ______________________________

____

13. Does your service provide mobile intensive care? [ ] Yes [ ] No

14. Does your service provide mobile neo-natal intensive care? [ ] Yes [ ] No

15. Does your service routinely provide first aid services to any sporting event, carnival, fair, etc? [ ] Yes [ ] No

If yes, state type, location, and number of patient encounters: ______________________________

____

____

16. Qualifications and number of EMS Personnel:

Employed	Contract	Volunteer	
______	______	______	Advanced First Aid and/or Red Cross
______	______	______	CPR Certificate Only
______	______	______	EMT Basic
______	______	______	EMT Advanced or Intermediate (IV)
______	______	______	EMT Paramedic
______	______	______	Nurse (RN or LPN)
______	______	______	Physicians or Surgeons*
______	______	______	Other, Describe: ______

* Attach list and indicate specialty.

17. Explain procedures for refusal or transfer by an adult: ______________________________

____

____

For refusal for transport by a minor: ______________________________

____

____

18. Explain criteria for "No-Transport" by service: ______________________________

____

____

19. Total number of all staff: ______________________________

Total payroll or remuneration paid last year: $______________________________

Estimated payroll or remuneration next year: $______________________________

20. Give name of Administrator/Supervisor and describe his/her training and experience: ______

____

21. Do you sell any products? [ ] Yes [ ] No

If yes, describe and indicate estimated annual sales for each:____________________

22. Do you rent or otherwise provide any equipment or products to others? [ ] Yes [ ] No

If yes, describe and indicate estimated annual sales for each:____________________

PART III. RISK MANAGEMENT

1. Name, qualifications, and number or years of experience of the Medical Director:

Name	Title	Experience/Training	Association Membership

2. Does your agency have a written credentialing policy and procedure for all individuals associated with or practicing within the agency? [ ] Yes [ ] No

3. Do you conduct pre-employment screening and investigation? [ ] Yes [ ] No

4. Do you prepare job descriptions and instructional manuals for your staff? [ ] Yes [ ] No

If so, enclose a copy of each.

5. Do you maintain a written clinical record showing the total number of visits by each category of staff for each patient or organization client? [ ] Yes [ ] No

6. Are patients accepted for health care services only upon a written plan of treatment established by an attending physician? [ ] Yes [ ] No

Explain any exceptions:____________________

7. Are you equipped with an emergency 24-hour telephone call line for all of staff and patients: [ ] Yes [ ] No

8. Do you enter into any contractual agreements (other than lease of premises agreements)? [ ] Yes [ ] No

If yes, attach explanation.

9. Does the applicant advertise its services other than an ordinary local telephone directory listing? If yes, please attach a copy of each advertisement. [ ] Yes [ ] No

10. Do you require staff to report all incidents (accidents) which might result in a liability claim **and** are records of such reports kept on file by you? [ ] Yes [ ] No

If not, are you agreeable to instituting this procedure? [ ] Yes [ ] No

11. Are the applicant and all professional employees licensed in accordance with applicable state and federal laws? If no, attach explanation of any exception. [ ] Yes [ ] No

12. Has the applicant or any of its employees:

    a) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital, or professional association? [ ] Yes [ ] No

    b) Had any professional license refused, suspended, revoked, renewal refused, or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? [ ] Yes [ ] No

    c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? [ ] Yes [ ] No

    If the answer to any of 12 is yes, please attach a detailed explanation.

13. Please describe in detail any additional operations, business pursuits, joint ventures in which your facility is currently engaged which would fall outside the scope of typical home health care operations. [ ] None [ ] Description Attached

PART IV. HISTORY

1. List prior **professional liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date?______________________________

2, List prior **general liability** insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Policy number	Limit of liability	Premium	Effective Dates	Claims-made (Y/N)

What is the most recent retroactive date?______________________________

3. Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? [ ] Yes [ ] No

If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved (attach an additional sheet if necessary):

____

____

____

____

4. Does any proposed insured have any knowledge of an event, circumstance, or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance, or occurrence? [ ] Yes [ ] No

If yes, describe the event and indicate the reason for anticipation of a claim:__________________

____

____

____

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation, and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and MarketScout, any documents, records, or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and applicant has not withheld information which is calculated to influence the judgment of the insurance company in considering this application.

Important: This application must be dated and signed by the applicant owner, partner, officer or administrator. Signing this form does NOT bind the company to complete the insurance.

____
Applicant Signature

____
Title

____
Date