PROFESSIONAL LIABILITY APPLICATION FOR MEDICAL ARTS SCHOOL

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. Total premises square footage occupied by applicant:_____

10. List memberships in professional organizations:_____

_____

11. 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. Does insured operate any outpatient/clinic operations? _____
   If yes, describe services provided: _____

   _____

   _____

5. Please provide length of classes instructed: _____

6. Enclose copies of each course curriculum.

7. Provide a breakdown of total number of students annually by classification:

   _____ # of EMT Basic; _____ # RN;

   _____# EMT Intermediate; _____ #Other (Describe) _____;

   _____# Paramedic; _____ #Other (Describe) _____;

   _____ # LVN; _____ #Other (Describe) _____;

8. Provide the number of staff/instructors by professional categories. Attach a separate sheet, if necessary

   _____

   _____

9. Enclose a description of all externship programs offered and copies of contracts with the facilities where the programs are conducted.

10. If no contracts exist, does insured provide staff instruction to supervise students in the program, or does the facility supervise the activities?

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