ALLIED HEALTHCARE DIAGNOSTIC IMAGING PROFESSIONAL LIABILITY APPLICATION

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. Telephone Number: Office:_____ Fax:_____

6. Person to Contact for Survey: Name:_____ Title:_____

7. Date Established:_____

8. The applicant is:
   [ ] Sole Practitioner
   [ ] Sole Proprietorship
   [ ] Partnership
   [ ] Corporation
   [ ] Other; Describe:_____

9. Gross Annual Receipts: Estimated Next 12 Months: $_____
   Last 12 Months: $_____

10. Entity is: [ ] For Profit [ ] Non-Profit
    Describe source of funds:_____

PART II. EXPOSURES

1. Number of **Professional Staff**: (**E = Employed; C = Contract**)

E	C		E	C	
_____	_____	Physicians	_____	_____	X-Ray Technicians
_____	_____	Technician Trainee	_____	_____	Clerical staff
_____	_____	Other:_____	_____	_____	Other:_____

2. Breakdown of patient services (%) by outpatient visits:

_____% CT Scanner	_____% SPECT
_____% Fluoroscope	_____% Ultrasound
_____% MRI	_____% X-Ray
_____% MRI with ESR	_____% Other:_____
_____% PET Scanner	_____% Other:_____

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

_____

_____

4. Total number of patient/client visits last year? _____

Estimated next year? _____

5. Is your facility owned by an M.D.? [ ] Yes [ ] No

If yes, indicate percentage of total services the owner's patient's tests represent: _____%

6. Describe the referral source(s) by which patients are directed to the entity:_____

7. Does your facility participate in any clinical trials or experimental procedures, equipment, or product testing? [ ] Yes [ ] No

If yes, attach separate sheet describing the facility's involvement and a copy of the protocol and any contracts involving same.

8. Does your facility own or operate any mobile diagnostic/imaging units? [ ] Yes [ ] No

If yes, indicate the manufacturer/uses/sites used and the gross receipts from each unit:_____

_____

_____

9. Is cardiac catheterization performed at your facility? [ ] Yes [ ] No

If yes:

(a) what equipment is utilized:_____

(b) who provides the cardiac monitoring:_____

(c) qualifications of the catheterization lab staff:_____

(d) are your catheterization staff members ACLS trained? [ ] Yes [ ] No

(e) describe the protocol for treating medication reactions:_____

(f) list equipment/meds ready for handling of life-threatening situations:_____

10. Are therapeutic procedures performed in your facility? [ ] Yes [ ] No

If yes,:

(a) is each procedure is performed by a qualified M.D.? [ ] Yes [ ] No

(b) who prescribes and sets dosage, and supervises the administration of any procedure?_____

_____

(c) who calibrates, and what is the frequency of calibration, for the equipment utilized in the procedure?_____

_____

11. Does your staff **inject** any solutions, medications, contrast media into any patients? | | Yes | | No

If yes, describe each substance and its usage, storage, and the number of dosages used annually: _____

_____

_____

14. Is a physician present to administer/supervise the injection of such substances? | | Yes | | No

15. Describe the protocol for treating adverse reactions:_____

_____

_____

16. Describe in detail your facility's policy and procedures for the supervision and transfer of temporary inpatient transfers where entity is responsible for the patient while on your premises:

_____

_____

17. What equipment, etc. does your facility have readily available for handling life-threatening situations?_____

_____

_____

18. (a) Are tests/film results interpreted or diagnosed by applicant? [ ] Yes [ ] No

(b) Are test /film results interpreted or diagnosed by third party under contract to applicant to provide said service? | | Yes | | No

If yes to (a) or (b), who diagnoses/interprets?_____

_____

Whose letterhead is used to send interpretations/results to clients?_____

If no, describe alternative arrangement, (e.g., statistical results only sent to client with no diagnostic interpretation or comment - client to provide own interpretation, or data sent to lab or other party of clients choosing for interpretation, etc.):

_____

_____

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

If yes, describe the product and estimate annual sales _____

_____

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

If yes, describe the product and estimate annual sales _____

_____

21. List memberships in professional organizations: _____

PART III. RISK MANAGEMENT

1. Total payroll last year: _____

Total payroll next year: _____

2. Do you desire coverage for independent contractor(s) as additional insured(s) on your policy while working on your behalf? [ ] Yes [ ] No

Do you require:

a) contracted staff to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? [ ] Yes [ ] No

If yes, indicate minimum limits required: _____

b) employed physicians, surgeons, nurse anesthetists, dentists, podiatrists or chiropractors to carry their own Professional Liability Insurance and secure Certificates of Insurance as evidence of such coverage? [ ] Yes [ ] No

If yes, indicate minimum limits required: _____

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

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

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

7. 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

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

Explain any exceptions: _____

_____

_____

_____

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

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

If yes, attach explanation.

11. Has the applicant or have any of the above employees:

a. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? [ ] Yes [ ] No

b. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? [ ] Yes [ ] No

c. ever been treated for alcoholism or drug addiction? [ ] Yes [ ] No

d. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? [ ] Yes [ ] No

If Yes to any of the above, please explain.

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 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