If your answer requires a larger space, please use the supplementary page instead. Please indicate: "see supplementary page".

PROFESSIONAL LIABILITY APPLICATION FOR CLINICS

Medical, Public Health, Dental, HMO, Ambulatory Surgical Centers,
Free Standing Emergency Centers

INSTRUCTIONS: ANSWER ALL QUESTIONS; IF THE ANSWER IS NONE, STATE NONE. IF THE QUESTION IS NOT APPLICABLE, STATE NOT APPLICABLE (N/A). IF THE SPACE PROVIDED IS INSUFFICIENT TO FULLY ANSWER THE QUESTION, PLEASE ATTACH A SEPARATE SHEET. NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

PART 1. GENERAL INFORMATION

1.1 Applicant Name:

1.2 Mailing Address:

1.3 Location Address(es):

1.4 Total premises square footage occupied by applicant:

1.5 County (parish) of each location:

1.6 Telephone Number: Office Fax

1.7 Person to contact for survey: Name
Title

1.8 Year entity established:

1.9 Entity is ☐ Individual ☐ Corporation ☐ Partnership
☐ Professional Association/Corporation ☐ Other. Describe

1.10 Entity is ☐ For Profit ☐ Non-Profit. Describe source of funds:

1.11 Proposed effective date

1.12 Requested Limits of Liability (if available):

Professional Liability $ /$

General Liability $ each occurrence
$ general aggregate

1.13 Annual Gross Receipts: Estimated next twelve months - $
Last twelve months - $

1.14 Annual Remuneration: Estimated next twelve months - $
Last twelve months - $

1.15 List all memberships in professional organizations:

NOTICE

THIS POLICY (IF ISSUED) IS ISSUED BY YOUR RISK RETENTION GROUP. YOUR RISK RETENTION GROUP MAY NOT BE SUBJECT TO ALL THE INSURANCE LAWS AND REGULATIONS OF YOUR STATE. STATE INSURANCE INSOLVENCY GUARANTY FUNDS ARE NOT AVAILABLE FOR YOUR RISK RETENTION GROUP.

PART 11. EXPOSURES

2.1 Breakdown of patient services (%) by outpatient visits:

% AIDS	% Gynecology	% Pediatric
% Alcoholic	% Hemodialysis	% Physical Rehab
% Bariatric	% Holistic Medicine	% Psychiatric
% Communicable	% Major Surgery	% Research/Experimental
% Dental	% Minor Surgery	% Stress Testing
% Disability	% Nutritional (diet)	% Substance Abuse
% Drug Addiction	% Obstetrical	% Other (describe)
% Emergency Med.	% Occupational	%
% Family Planning	% Optometry	%
% General Exams	% Orthopedic	%

2.2 Indicate the number of professional employees, volunteers and independent contractors: IF NONE, STATE NONE.

2.2.1 Physicians, Surgeons & Dentists	No. of Employees and Volunteers	No. of Independent Contractors
a) Physicians: No surgery (other than incisions of boils, suturing of skin) or other obstetrical procedures)		
b) Physicians: Minor surgery or obstetrical procedures not constituting major surgery		
c) Proctologists, Ophthalmologists and Urologists		
d) General Surgeons, Cardiac Surgeons, and Otolaryngologists (no plastic surgery)		
e) Obstetrics-Gynecologists, Plastic Surgeons and Otolaryngologists doing plastic surgery		
f) Anesthesiologists, Thoracic Surgeons, Vascular Surgeons, Neurosurgeons, and Orthopedic Surgeons		
g) Physician's & Surgeon's Assistants, Nurse Practitioners (describe duties on separate sheet)		
h) Unlicensed Interns		
i) Dentists (no oral surgery)		
j) Orthodontists		
k) Oral Surgery		

IF ANY OF THESE CATEGORIES ARE PROVIDING SERVICES, COMPLETE PHYSICIAN EXPOSURE SUPPLEMENT.

2.2.2 Allied Health Professionals

	No. of Employees and Volunteers	No. of Independent Contractors		No. of Employees and Volunteers	No. of Independent Contractors
a) Chiropractor			l) Pharmacist		
b) Dental Hygien			m) Phys. Therapist		
c) Dialysis Technician			n) Physician's Asst.		
d) EEG/EKG Technician			o) Podiatrist		
e) Medical Lab Tech.			p) Social Worker		
f) Nurse Anesthetist			q) Psychotherapist		
g) Nurse Midwife			r) Radiation Tech.		
h) Nurse Practitioner			s) Resp. Therapist		
i) Occupational Therapist			t) RN, LVN, LPN		
j) Optician/Optornotrist			u) Speech Therapist		
k) Perfusionist			v) Surgical Tech.		

2.3 Are all of the above individuals licensed in accordance with applicable state and federal regulations?
Yes No If no, attach explanation.

2.4 Describe hiring & verification processes for all employed/independently contracted physicians.

2.5 Does the applicant supervise any individuals other than those listed above? Yes No
If yes, on a separate sheet provide detailed explanation of responsibilities and relationship to the entity which employs these individuals. Also, indicate by profession the number of individuals supervised.

2.6 Does the applicant maintain any beds for overnight occupancy? Yes No
If yes, indicate the number # type and the number of patient days the last 12 months

2.7 Please provide the number of outpatient visits by category.

Type	No. of Visits/Tests Next Twelve Months	Last Twelve Months
Clinics - Total		
a. Physician		
b. Dentists		
c. Physician Asst./Nurse Practitioner		
d. Other Allied Health Professionals		
e. Laboratory		
f Emergency Room		
g. Surgery (procedures)		
h. Imaging/X-Ray		
i. Other		

2.8 Does the clinic provide medical services for other than fee for service? Yes No
If yes, give details or arrangements, including a copy of contract(s).

2.9 What is patient mix? Fee for service % Prepaid %

2.10 What percent of prepaid patients are referred to outside physicians? %.

2.11 Does the applicant perform:

a. Acupuncture or acupuncture anesthesia? Explain ☐ Yes ☐ No

b. Angiography/Arteriography/Venography? Explain ☐ Yes ☐ No

c. Catheterization (other than urinary or umbilical?) Describe procedure. ☐ Yes ☐ No

d. Closed reduction of compound fractures and/or Dermabrasion? ☐ Yes ☐ No

e. Injection of radioisotope and/or use of irradiated substances? Describe. ☐ Yes ☐ No

f Radiation Therapy and/or Chemotherapy? Describe. ☐ Yes ☐ No

9. Electroconvulsive Therapy? ☐ Yes ☐ No

h. Silicone Injections? Describe. ☐ Yes ☐ No

i. Laser Treatment? Describe. ☐ Yes ☐ No

J. Experimental procedures or research testing? Describe in detail on separate sheet. ☐ Yes ☐ No

k. Hypnosis? Describe. ☐ Yes ☐ No

l. X-Ray Services? If yes, number of annual X-ray exposures for diagnosis: ☐ Yes ☐ No

for treatment What qualifications are required of the staM

m. Does the applicant prescribe drugs for weight reduction of patients? ☐ Yes ☐ No

n. Are any of the following preformed?

1) Obstetrics

a) Pre-natal ☐ Yes ☐ No

b) Deliveries ☐ Yes ☐ No

c) Elective or therapeutic abortions ☐ Yes ☐ No

d) If clinic provides pre-natal care only, does clinic physicians or nurse midwife attend patient at designated hospital at time of delivery? ☐ Yes ☐ No

e) if answer to d) is no, are clinic pre-natal records provided to delivering physician and to the designated hospital prior to delivery? ☐ Yes ☐ No

2) Chemical/Sub stance Abuse Services

a) Counseling ☐ Yes ☐ No

b) Methadone or similar substances, dispensed or prescribed. ☐ Yes ☐ No

c) If the answer to b) is yes, describe on a separate sheet treatment and controls used, and indicate number of treatments during last twelve months:

Next twelve months:

3) Do you provide home health care services? ☐ Yes ☐ No

If yes, do they account for more than 5% of your gross revenue? ☐ Yes ☐ No

If yes, please complete and attach our Home Health Care Service Application.

2.12 Is your facility owned by an M.D: ☐ Yes ☐ No If yes, owner name(s):

2.13 Is the applicant in the employ of any federal governmental entity? ☐ Yes ☐ No

If yes, attach explanation.

2.14 Is the applicant under contract to any federal governmental entity? ☐ Yes ☐ No

If yes, attach explanation.

2.15 Name and give locations of any hospitals or institutions the applicant uses in practice and describe how affiliated.

2.16 In what states is the applicant registered and licensed to practice?

2.17 Does the applicant own (wholly or in part), operate, or administer any hospital, nursing home or other institution where medical services are customarily rendered?s ☐ Yes ☐ No
If yes, give, details, including name, location, size and number of beds.

2.18 Does applicant own or operate any business other than that shown in ☐ Yes ☐ No
Question 2.17 above? If yes, please give details on separate sheet.

2.19 Does applicant perform or engage in any surgical procedure(s) in its professional office or similar non-hospital facility? ☐ Yes ☐ No. If yes, answer the following:
a. Please submit detailed list of all surgical procedures performed at the center.
b. Provide the number of procedures performed the last 12 months for each procedure listed in A. above.
c. For each procedure breakdown the number performed under general anesthesia (including IV sedation) versus local (topical of local infiltration)

2.20 Is anesthesia (other than topical or by means of local infiltration) administered by applicant?
☐ Yes ☐ No If yes, describe in detail by whom, whether employed or contracted, a list of agents utilized, whether an oxymeter is used, and attach a copy of the written policies and/or guidelines of the anesthesia service. If a CRNA administers anesthesia, include the CRNA under the Physician Exposure Supplement.

2.21 Does the applicant perform any:

a. Surgery other than incision of superficial boils or suturing superficial fascia? ☐ Yes ☐ No
b. Circumcisions and/or dilation and curettage and/or insertion of temporary pacemakers? ☐ Yes ☐ No
c. Tonsillectomies and/or Adenoidectomies and/or Caesarean Sections? ☐ Yes ☐ No
d. Cosmetic Plastic Surgery? Describe ☐ Yes ☐ No
e. Excision of large cysts and/or I&D of deep-seated boils or carbuncles? ☐ Yes ☐ No
f Hysterectomies? ☐ Yes ☐ No
9. Open reduction of fractures? Describe. ☐ Yes ☐ No
h. Surgery for weight reduction of patients? ☐ Yes ☐ No
i. Abortions and/or menstrual extractions? Describe (include trimester, method and number of abortions performed per month). ☐ Yes ☐ No
J. Cryosurgery (other than use on benign or pre-malignant dermatological lesions? Describe. ☐ Yes ☐ No
k. Silicone Implants? Describe. ☐ Yes ☐ No
1. Sterilization Procedures? Describe. ☐ Yes ☐ No
m. Biopsies and/or endoscopies? List types performed. ☐ Yes ☐ No
n. Sex change operations? Describe and advise number yearly. ☐ Yes ☐ No
o. Experimental surgery or surgical research? Describe on separate sheet. ☐ Yes ☐ No
p. Other Surgery? Describe. ☐ Yes ☐ No

2.22 Does the applicant have the following equipment at the center:

a. Laboratory with the following capabilities - CBC, UA electrolytes, blood sugar, arterial blood gases, pregnancy test, bun, and/or creatinine ☐ Yes ☐ No
b. X-ray with on premises processing ☐ Yes ☐ No
c. EKG - 12 lead ☐ Yes ☐ No
d. Monitor/Defibrillator ☐ Yes ☐ No
e. Crash cart with full cardiac life support capabilities and necessary intravenous fluids. ☐ Yes ☐ No
f Appropriate trays and equipment for accessing the airway,

pericardiocentesis, needle thoracostomy, transvenous or transthoracic, pacemaker, venous access, gastric lavage ☐ Yes ☐ No

9. Oxygen ☐ Yes ☐ No

h. Suction ☐ Yes ☐ No

I. Pneumatic anti-shock trousers ☐ Yes ☐ No

J. Dedicated telephone line to the closest appropriate hospital emergency department and/or two-way communication with the EMS ☐ Yes ☐ No

2.23 Describe peer review process for surgeons on a separate sheet.

2.24 Does the applicant perform gynecology:

a. Surgical ☐ Yes ☐ No

b. Family Planning ☐ Yes ☐ No

If yes, indicate number of patients _____ Describe range of services:

PART 111. RISK MANAGEMENT

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

Name	Title	Experience/Training	Association Membership

3.2 Who does the supervising of staff, and what is his/her experience?

3.3 Does your clinic require the professional staff be CPR trained? ☐ Yes ☐ No

3.4 Describe the referral source(s) by which patients are directed to the entity.

3.5 Does the clinic have a written policy and procedure to assure that contractors' credentials, liability insurance coverage and standards of performance are commensurate with entity's? ☐ Yes ☐ No

3.6 Do your contracts with vendors specify responsibilities, performance goals, warranties, liability insurance, and possible termination by either party? ☐ Yes ☐ No

3.7 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:

3.8 Is applicant approved to receive Medicare and Medicaid payments? ☐ Yes ☐ No

3.9 Does the applicant have a qualified physician(s) and other personnel trained in emergency medical care in the center during all hours of operation? ☐ Yes ☐ No

Please describe.

3.10 Do you have any restricted licensed physicians on staM ☐ Yes ☐ No

If yes, explain on separate sheet.

3.11 Do you have any physicians on staff that do not maintain staff privileges at a hospital? If yes, explain. ☐ Yes ☐ No

3.12 Does the applicant participate in any activity (e.g. newspaper columns, broadcasts, etc.) whereby professional advice is offered to the public?

If yes, please attach detailed explanation of this activity. ☐ Yes ☐ No

3.13 Does the applicant advertise its professional services in any manner (other than a simple listing in a telephone directory)? ☐ Yes ☐ No

If yes, attach a copy of ALL of the advertisements.

3.14 Is the applicant associated with any agency or organization that engages

in any kind of advertising for or solicitation of patients? ☐ Yes ☐ No

If yes, attach detailed explanation and a copy of ALL of the advertisements.

3.15 Does the applicant use a collection agency? ☐ Yes ☐ No

If yes, give name of agency:

Has the agency authority to file a collection suit at its discretion? ☐ Yes ☐ No

3.16 Is the applicant and all professional employees licensed in accordance with applicable state and federal laws? ☐ Yes ☐ No

If no, attach explanation of any exception.

3.17 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 3.17 IS YES, PLEASE ATTACH A DETAILED EXPLANATION.

PART IV. **HISTORY**

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

	Insurer	Policy Number	Limits of Liability	Premium	Eff Date	Claims-Made Yes	Claims-Made No
1.						☐	☐
2.						☐	☐
3.						☐	☐
4.						☐	☐
5.						☐	☐

If claims-made, what is the most recent retroactive date?

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

	Insurer	Policy Number	Limits of Liability	Premium	Eff Date	Claims-Made Yes	Claims-Made No
1.						☐	☐
2.						☐	☐
3.						☐	☐
4.						☐	☐
5.						☐	☐

If claims-made, what is the most recent retroactive date?

4.3 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).

4.4 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 Mid-Continent General Agency, Inc. 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 that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

Date

Applicant/Title

Supplementary Page

Please reference the number of the question to which these responses apply.