





- 2.10 Are therapeutic procedures performed in your facility? Yes No  
 If yes, Indicate (a) whether each procedure is performed by a qualified M.D., or who performs the procedure  
 (b) who prescribes and sets dosage, and supervises the administration of the procedure  
 (c) who calibrates, and what is the frequency of calibration, for the equipment utilized in the procedure
- 2.11 Does your staff **inject** any solutions, medications, contrast media into any patients? Yes No  
 If yes, fully describe each substance and its usage, its storage and the number of dosages annually of each:
- 2.12 Is a physician present to administer/supervise the injection of such substances? Yes No
- 2.13 Describe the protocol for treating adverse reactions
- 2.15 Describe the occupied building fully, including: Own Lease Rent  
 Construction Age of Bldg Number Stories  
 Sq. Ft. Area Wiring Type/Age Prot. Class  
 Smoke Detectors Fire Alarm Central Local  
 Sprinklered Fully Partially Distance Nearest Fire Hydrant
- 2.16 Does applicant provide any professional services under contract ? Yes No  
 If yes attach copy of contract (s) or samples if many are identical.
- 2.17 **Attach** copy of **letterhead**, service description / advertising **brochures** / **flyers**.

**PART III. RISK MANAGEMENT**

- 3.1 Name, qualifications and years of experience of the Medical Director, manager, supervisors:  
 Name Title / Degree Experience/Training Assn. Membership
- 3.2 List applicant entity's memberships in professional organizations:
- 3.3 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.
- 3.4 Is the applicant and are all professional employees / contractors licensed in accordance with applicable state and federal laws? Yes No If no, explain
- 3.5 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:
- 3.6 What equipment, etc. does your facility have readily available for handling life threatening situations?
- 3.7 Are tests / film results interpreted or diagnosed by applicant? Yes No

Are tests / film results interpreted or diagnosed by third party under contract to applicant to provide said service? Yes      No  
 If Yes in either situation, who diagnoses / interprets ?

Whose letterhead is used to send interpretations / results to client ?  
 If No, describe alternative arrangement, ( i.e. 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 )

3.8 Are radiation meters worn by your professional staff? Yes      No  
 If yes, are regular checks for exposure made? Yes      No

3.9 Describe the patient screening process your facility utilizes for pregnancy, pacemakers, artificial valves, etc.

3.10 Does your facility require the professional staff to be CPR trained ? Yes      No

3.11 Who performs the following in your facility?  
 a. Calibration of diagnostic equipment? Contractor Employee  
 b. Services/Maintains diagnostic equipment? Contractor Employee  
 If contractors perform either function, attach copy of contract. If employee, advise position and qualifications.

3.12 Have there been any equipment failures/problems resulting in injury to a patient? Yes      No  
 If yes, describe event(s) and steps taken to avoid recurrence

3.13 Do you have policies and procedures in place to report all applicable problems with medical devices to the Federal Drug Administration? Yes      No

3.14 Are logs kept of all servicing, maintenance, calibration of precision instruments? Yes      No

3.15 Does applicant, or any agency or association on its behalf advertise its professional services in any manner other than a simple listing in the telephone directory? Yes      No  
 If yes, attach a copy of all advertisements.

3.16 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 3.15 IS YES, PLEASE ATTACH A DETAILED EXPLANATION.**

3.17 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 imaging center operations. Give Name / Address / Description of Operations / Common Ownership:(or state NONE)

**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	Claims-Made Form		
				Eff. Date	Yes	No

- 1.
- 2.
- 3.
- 4.
- 5.

If claims-made form, what is the most recent **retroactive date**? If Prior Acts coverage being requested by new applicant, Prior Acts supplemental application must be completed.

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	Claims-Made Form		
				Eff. Date	Yes	No

- 1.
- 2.
- 3.
- 4.
- 5.

If claims-made form, 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 applicant has not withheld any information calculated to influence the judgment of the insurance company in considering this application.

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

Date

\_\_\_\_\_  
Applicant/Title

# Supplemental information:

(please reference any questions you are referring to)