If your answer is too long, then please complete it on the supplemental page, referencing the question number.

PROFESSIONAL LIABILITY APPLICATION
for
MEDICAL LABORATORIES

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 I. GENERAL INFORMATION

1.1 Applicant Name:

1.2 Mailing Address:

1.3 Location Address(es):

1.4 County (parish) of each location:

1.5 Telephone Number: Office Fax

1.6 Person to contact for survey: Name
Title

1.7 Year entity established:

1.8 Entity is ☐ Individual ☐ Corporation ☐ Partnership
☐ Professional Association/Corporation ☐ Other. (Describe)

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

1.10 Proposed effective date

1.11 Requested Limits of Liability (if available):
Professional Liability $ /$
General Liability $ each occurrence
$ general aggregate

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

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

1.14 Total Premises Square Footage Occupied by Applicant:

PART II. EXPOSURES

2.1 Describe fully the operations, activities, services and professional procedures administered:

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.

2.2 Attach a list by major category of all tests performed in the last annual period. Indicate percentage breakdown of all tests by type.

2.3 Employees

Total Number of Full Time (including all employees)

Total Number of Part Time (including all employees)

Number/FTE		Professional Type
		Physicians-employed (other than Medical Director)*
		Physician-contract (attach copy of contract)*
		Bioanalysts
		Cytotechnicians
		Technologist
		Technologist-trainee
		Other (Describe)

* If any, please complete Physician's Exposure Supplement

2.4 Does the laboratory own or operate any mobile laboratories? ☐ Yes ☐ No

If yes, indicate manufacturer and the gross receipts from each unit:

2.5 Is your facility owned by an M.D.? ☐ Yes ☐ No.

If yes, owner name(s)

If yes, indicate annual number and % of facility total that represents the owner's patient's tests:

%

2.6 If the answer to any part of this question is yes, attach a separate sheet and provide details (i.e. specific tests performed, number of tests performed per year, percentage of gross annual receipts).

a) Are you involved in any blood banking or crossmatching? ☐ Yes ☐ No

b) Are you involved in any intravenous transfusion or in the procurement of blood and/or its components? ☐ Yes ☐ No

c) Are you involved in any medical, genetic or drug research? ☐ Yes ☐ No

d) Are you involved in the manufacturing, dispensing or testing of pharmaceuticals? ☐ Yes ☐ No

e) Do you manufacture and/or sell laboratory equipment or supplies? ☐ Yes ☐ No

f) Do you perform any type of environmental analyses? ☐ Yes ☐ No

g) Are you involved in any services open to the public (health fairs, shopping mall exhibits)? ☐ Yes ☐ No

h) Do you send tests to reference labs? ☐ Yes ☐ No

If yes, please state % of receipts: 0.00%

Reference Lab Name:

Location:

2.7 Does your staff perform arterial sticks? ☐ Yes ☐ No

If yes, who performs? 0.00%

If yes, what restrictions and precautions are utilized?

2.8 Does your staff perform PAP Smears? ☐ Yes ☐ No

If yes, who performs the test?

If yes, who reads and interprets the results?

2.9 Does the applicant provide drug screening for any entity? ☐ Yes ☐ No

If yes, please attach copies of all applicable contract types and a copy of the applicant's policy on confidentiality.

2.10 Does the applicant perform HIV testing? ☐ Yes ☐ No
If yes, please attach consent/disclosure form, copies of any contracts, and the applicant's policy on confidentiality.

2.11 Are biopsies performed by the applicant? ☐ Yes ☐ No
If yes, specify type and number:

2.12 Does applicant prepare any immunological, pharmaceutical or similar agents?
☐ Yes ☐ No If yes, describe:

2.13 Does your facility manufacture or distribute any "test kits" used by others, including any "home test kits"? ☐ Yes ☐ No If yes, describe in detail each type of kit, indicate gross receipts for each type of kit, and specify which kits your facility manufactures.

2.14 Are test results interpreted or diagnosed by applicant? ☐ Yes ☐ No
If yes, who diagnoses/interprets?

2.15 Are diagnoses made by any non-physician members of your staff? ☐ Yes ☐ No
If yes, please provide on a separate sheet their qualifications, and who else reviews the diagnoses.

2.16 Are any patients ever present at the laboratory premises for the purpose of testing, obtaining specimens or any other reason? ☐ Yes ☐ No
If yes, are any of the patients transfers from a healthcare facility? ☐ Yes ☐ No
If yes, who is responsible for these patients while they are on your premises?
☐ Your staff ☐ Accompanying staff

2.17 Describe the occupied building fully, including: Age

Construction | No. of stories
Last remodeled | Sprinklered ☐ Fully ☐ Partially ☐ None
Smoke Alarms | Fire Alarms

2.18 Does applicant provide any services under contract? ☐ Yes ☐ No
If yes, attach explanation and a copy of the contract.

2.19 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.

2.20 Is your facility owned by, or operated in, a hospital? ☐ Yes ☐ No
If yes, which hospital?

PART III. RISK MANAGEMENT

3.1 Name, qualifications and number of years of experience of the Medical Director, all Managers and Supervisors:

Name	Title	Experience/Training	Association Membership

3.2 List All Memberships in Professional Organizations.

3.3 Are your technologist graduates of medical technology programs? ☐ Yes ☐ No
If not, indicate exceptions and cite qualifications.

3.4 Is your facility eligible for certification or accreditation? ☐ Yes ☐ No
If yes, is applicant certified and/or accredited? ☐ Yes ☐ No
If yes, by whom?
If no, explain the reason.

3.5 Describe the method and frequency of internal Quality Assurance screens of test results:

3.6 Are random tests performed to audit false positive results? ☐ Yes ☐ No
False negatives? ☐ Yes ☐ No If no, to either question, please explain the reason.

3.7 How long does your lab retain blood, tissue, other specimens for future reference?

3.8 What professional organization's standards are followed by your lab?

3.9 How frequently are reagents checked?

3.10 Who calibrates the precision equipment in your facility?
What is the frequency of those calibrations?

3.11 Who services and maintains the precision equipment in your facility?
What is the frequency of servicing?

3.12 Are logs kept of the calibration and servicing of precision instruments? ☐ Yes ☐ No

3.13 Are your staff CPR trained? ☐ Yes ☐ No

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

3.15 Is the applicant and all professional employees licensed in accordance with state and federal laws? ☐ Yes ☐ No
If no, attach explanation of any exception.

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 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 3.16 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?

4.3 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 nay 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

Supplemental information:

(please reference any questions you are referring to)