

Instructions:

The requested information is necessary before a quotation can be obtained.

Type or print clearly.

Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the appropriate space. Any spaces left blank will be interpreted to not apply.

Provide any supporting information on a separate sheet and reference the applicable question number.

Use Y for Yes or No answers and other selections.

This application must be completed, dated and signed by an authorized representative of the applicant. Underwriters will rely on all statements made in this application

The information requested in this application is for underwriting purposes only and does not constitute notice to the Company under any Policy of a claim or potential claim. All such notices must be submitted to the Company pursuant to the terms of the Policy, if and when issued.

NOTICE: This supplement is part of the main Healthcare/Miscellaneous Facilities Liability Application and is subject to the same warranties, representations and conditions. All relevant sections of the main application also apply to, and shall contemplate, applicants subject to this supplement. This includes but is not limited to the main application sections for Loss Experience, Coverage Requested, Exposures (prospective and historical Professional Liability, General Liability, Home Health Care and/or Hospice Services, Staffing Agency Services, Aircraft Liability, Automobile Liability, Watercraft Liability, and Employer's Liability), Excess Liability, Professional Employees and Staff, License/Certification Information, Risk Management, Employment Practices, Previous Insurance, Prior Acts Warranty (if applicable), Fraud Warning, Declaration & Certification, and Signature.

SECTION A. – APPLICANT/OWNERSHIP

1. List all partners, members or stockholders/owners of the applicant and their respective percentage of ownership interest:

Name	Ownership %	Name	Ownership %
	%		%
	%		%

SECTION B. – TYPES OF SERVICES PROVIDED

- 1. Does the applicant maintain beds for overnight recovery or occupancy? Yes No
 - a. 23 hours or less? Yes No
If Yes, number:
 - b. 24 hours or more? Yes No
If Yes, number:
 - c. Any licensed hospital beds or is the facility licensed as a surgical hospital? Yes No

2. Select each type of surgical service that applies to the applicant and provide the number of visits (1):

Type of Procedure	Projections for Current or Expiring Year	Projections for Requested Coverage	Type of Procedure	Projections for Current or Expiring Year	Projections for Requested Coverage Period

Type of Procedure	Projections for Current or Expiring Year	Projections for Requested Coverage Period	Type of Procedure	Projections for Current or Expiring Year	Projections for Requested Coverage Period
Bariatric			Ophthalmology (cataracts)		
Cardiac Catheterization			Oral and Maxillofacial		
Colon and Rectal			Orthopedic		
Cosmetic			Otolaryngology (ENT)		
Endoscopy			Pain Management		
Gastroenterology			Plastic (reconstructive)		
General			Podiatry		
Gynecology			Thoracic		
Hand			Urology		
Head and Neck			Vascular		
Neurology			Wound Care		
Obstetrics			Other – describe:		
Ophthalmology (Lasik, PRK, TKP)					

(1) Visit: One visit applies each time a patient enters the facility for healthcare related services regardless of the number of departments visited or the number of procedures/treatments performed within each department. Each threshold crossing for a pre-surgical and post-surgical visit is counted as a separate visit apart from the number of surgeries or procedures.

SECTION C. – ANESTHESIOLOGY SERVICES

1. Select all levels of anesthesia administered by the applicant:

Class A	Topical or local anesthesia including digital and pudendal blocks.
Class B	Intravenous or parenteral sedation, regional anesthesia including epidural and spinal blocks, analgesia or dissociative drugs without the use of endotracheal or laryngeal mask intubation or inhalation anesthesia (including nitrous oxide).
Class C	Endotracheal or laryngeal mask intubation or inhalation anesthesia (including nitrous oxide).

2. Using the ASA Physical Status Classification scale, indicate the percentage of the applicant's patients rated in each category for the previous 12 month period:

P1	A normal healthy patient.	%
P2	A patient with mild systemic disease.	%
P3	A patient with severe systemic disease.	%
P4	A patient with severe systemic disease that is a constant threat to life.	%
P5	A moribund patient who is not expected to survive without the operation.	%
P6	A declared brain-dead patient whose organs are being removed for donor purposes.	%

3. Are all anesthetics administered by either a qualified physician or C.R.N.A. (under physician supervision if required by state or the facility)?

If No, explain:

Yes No

SECTION D. – CREDENTIALING

1. Number of active physician medical staff members:

2. Does the applicant have a formal credentialing program that includes all physicians and anesthesiologists?

Yes No
If No, explain:

3. Does the applicant confirm that all physicians working at its facility have current hospital privileges?

Yes No

4. Are clinical privileges for physicians and anesthesiologists based on training and peer review? Yes No

5. Are all physicians on staff board certified in the specialty in which they are practicing?

review? Yes No

- 5. Are all physicians on staff board certified in the specialty in which they are practicing?
Yes No

If No, explain:

- 6. Does the applicant secure written evidence that all medical professionals on staff carry a minimum of \$1,000,000 Each Occurrence/\$1,000,000 Aggregate professional liability insurance? Yes No

If No, explain:

SECTION E. – GENERAL SAFETY

- 1. Are the applicant’s facilities constructed, equipped and operated in accordance with applicable local, state and federal laws and regulations including, at a minimum, a reliable source of oxygen, suction, resuscitation equipment and emergency drugs? Yes No

If No, explain:

- 2. Has the applicant fully implemented the National Patient Safety Goals? Yes No

If No, explain:

- 3. Does the applicant have a written policy and procedures in place for each of the following:

Patient identification:	Yes No
Surgical site verification:	Yes No
Patient positioning:	Yes No
Laser/electrical safety:	Yes No
Continuous physiological monitoring:	Yes No
Documentation of all intra-operative orders:	Yes No
Disposition of all pathology and other specimens:	Yes No
Verification of sponge, needle and instrument counts:	Yes No
Documentation of patient condition, mode of transport for hospital transfers:	Yes No
Completion and signing of operative reports which includes a written, immediate post-surgical report:	Yes No
Medical Devices involved in patient injuries:	Yes No

- 4. Does the applicant have written emergency transport policy and procedures and an agreement in place with a local hospital? Yes No
- 5. Number of miles from the applicant’s facility to the nearest hospital:

The Applicant warrants to the Company that all statements made in this supplement are true and complete and no material facts have been misrepresented or misstated in this supplement or have been concealed or suppressed.

The Applicant understands that this form is part of the main Healthcare/Miscellaneous Facilities Liability Application and is subject to the same warranties, representations and conditions.

Signature of Applicant Date

Title

