



- Ace American Insurance Company
- Illinois Union Insurance Company
- Westchester Surplus Lines Insurance Company

Healthcare/Miscellaneous Facilities  
Liability Application  
Imaging & Therapeutic Radiology Supplement

**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 %
	%		%
	%		%

2. Indicate the percentage of imaging services provided in a physician's office: %
3. Are any physician-owners making self-referrals to the facility?  
Yes No

Not Applicable

If Yes, what percentage of total receipts is generated from self-referrals? %

**SECTION B. – EXPOSURES**

- Provide gross receipts for all exposures applicable to the applicants. Receipts should not be adjusted for uncollectible accounts or other obligations and should include receipts from block-leasing arrangements, if applicable.

Gross Receipts		
Services	Projections for Current or Expiring Year	Projections for Requested Coverage Period
Imaging/Diagnostic Radiology – Non-Invasive Procedures	\$	\$
Imaging/Diagnostic Radiology – Invasive Procedures (1)	\$	\$
Therapeutic Radiology/Radiology Oncology	\$	\$

(1) Invasive procedures involve insertion of instruments such as needles and catheters, or dyes and/or small amounts of radioactive materials, in the body.

- Does any applicant interpret or diagnose results of tests or films? Yes No  
If Yes, explain:

- If teleradiology services are provided, is the “reading” physician licensed in all states in the service area?  
Yes No Not Applicable

- Are any teleradiology services or readings provided outside the United States and its territories?  
Yes No

If Yes, explain:

- If therapeutic procedures are performed at the applicant’s facility, who prescribes dosage/medications and supervises administration?

- Does the applicant lease space, equipment and/or technicians to third parties for a designated period of time to allow third parties to bill and receive payment from payors for the technical and professional component of the services (known as block-leasing)?  
Yes No

If Yes, provide:

- Annual Lease Revenue: \$
- Percentage of Gross Receipts included in Item 1. generated by third parties: %

- Does the applicant engage in any other operations, business pursuits or joint ventures that have not been described previously?  
Yes No

If Yes, explain:

**SECTION C. – PROFESSIONAL EMPLOYEES AND STAFF**

- Select the physician specialties utilized by the applicant for the professional component or interpretation of imaging procedures:

SPECIALTY		Physicians’ Relationship to the Applicant
Diagnostic Radiology:	Yes No	Employed Contracted Independent Staff
Interventional Radiology:	Yes No	Employed Contracted Independent Staff
Nuclear Medicine:	Yes No	Employed Contracted Independent Staff
Nuclear Cardiology:	Yes No	Employed Contracted Independent Staff
Other – list:	Yes No	Employed Contracted Independent Staff

If Other applies, describe the minimum level and training and experience required by the applicant for the medical staff interpreting images:

- List qualifications of physician safety officer:

2. List qualifications of physician safety officer:
3. Do technicians or technologists hold other specialized certificates?  
Yes No

If Yes, list the certificates held:

4. Are all allied health care professionals trained and recertified annually in Basic Cardiac Life Support?

Yes No

**SECTION D. – RISK MANAGEMENT/POLICIES AND PROCEDURES**

1. Does the applicant have protocols for the use of the following contrast media?

Ionic:	Yes No
Non-Ionic:	Yes No
Los osmolar:	Yes No

2. Does the applicant's staff inject any solutions, medication or contrast media into patients?

Yes No

If Yes:

- a. Is a physician present during the procedure?  
Yes No
- c. Describe emergency protocol for treating adverse reactions:

1. Does the applicant have a second radiologist review normal images?  
Yes No

2. Does the applicant use a computer-aided system for the detection of abnormalities for screening mammograms?  
Yes No

3. Select the frequency of the applicant's QI process for reviewing ultrasounds, x-ray films and patient medical records:  
Weekly Monthly

6. Who is responsible for providing tests results to the patient?

Is this required to be documented?

Yes No

If Yes, how is it documented?

7. Is there a process for communicating results to the patient and the patient's practitioner?

Yes No

If Yes, describe the process:

8. How are telephone conversations between the radiologist and ordering physician documented in the patient record?

9. Is there a fall prevention program to identify high-risk patients?  
Yes No

10. Does the applicant have an external peer review program for high-risk/high-volume studies or images?  
Yes No

If No, describe peer review process:

11. Are emergency equipment and medications available?  
Yes No

If Yes, what equipment is on hand?

**SECTION E. – EQUIPMENT**

1. Does the applicant's radiology department have a written equipment maintenance

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1. Does the applicant’s radiology department have a written equipment maintenance program that includes documentation of:

Periodic Calibrations	Yes No
Quality Assurance Studies	Yes No
Routine Safety Surveys	Yes No
Monthly Inspection and Preventative Maintenance Activities	Yes No

2. Concerning the inspection and maintenance (including, but not limited to, calibration) of all equipment, does the applicant have the following on file?

A plan or contract that specifically identifies when inspections and maintenance will occur:	Yes No
A log of dates of when inspections and maintenance are completed:	Yes No
A file of all past and current correction action measures taken as recommended:	Yes No

**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

Title

Date