

10. a. List the number and type of applicant's employees and volunteers: If None, State None. _____

Number	Type of Profession	Number	Type of Profession
1) _____	Inhalation Therapists	9) _____	Perfusionists
2) _____	Laboratory Technicians	10) _____	Pharmacists
3) _____	Nurse Anesthetists	11) _____	Physicians – Minor Surgery
4) _____	Nurses, Licensed Practical	12) _____	Physicians – No Surgery
5) _____	Nurse Practitioner	13) _____	Physiotherapists
6) _____	Nurses Registered	14) _____	Social Workers
7) _____	Opticians	15) _____	Speech Therapists
8) _____	Optometrists	16) _____	Other

b. List the number and type of independent contractors who provide professional services on behalf of the applicant.

If None, State None _____

c. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes No

ATTACH DETAILED EXPLANATION FOR ANY "YES" ANSWERS:

Has the applicant or have any of the above employees:

- 1) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes No
- 2) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No
- 3) Ever been treated for alcoholism or drug addiction? Yes No
- 4) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes No

11. Does the applicant perform:

- a. Acupuncture or acupuncture anesthesia? Explain: _____ Yes No
- b. Angiography/Arteriography/Venography? Describe: _____ Yes No
- c. Catheterization (other than urinary or umbilical)? Describe: _____ Yes No
- d. Closed reduction of compound fractures and/or normal deliveries and/or dermabrasion? Yes No
- e. Injection of radioisotopes and/or use of irradiated substances? Describe: _____ Yes No
- f. Radiation Therapy and/or Chemotherapy? Describe: _____ Yes No
- g. Psychiatric shock therapy? Yes No
- h. Silicone Injections? Describe: _____ Yes No
- i. Spinal Anesthesia (other than saddle blocks or caudals)? _____ Yes No
- j. Laser Treatment? Describe: _____ Yes No

12. 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
- g. 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. Silicone Implants? Describe: _____ Yes No
- k. Sterilization Procedures? Describe: _____ Yes No
- l. Biopsies and/or endoscopies? List types performed: _____ Yes No
- m. Sex change operations? Describe and advise the number performed per year: _____ Yes No
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- n. Other Surgery? Describe: _____ Yes No
13. Does the applicant perform hospital emergency room care?
- a. For its own regular patients? Yes No
- b. For patients not its own? Yes No
- c. If answer to b. is yes, please specify: the percentage of its time devoted to this work = (_____)%, the number of hours per month devoted to this work = (_____) hrs.
14. Does the applicant use drugs for weight reduction patients? Yes No
If yes, on last page list drugs used and advise: percent of practice devoted to weight reduction, frequency and duration of prescriptions for weight reduction drugs and quantity dispensed by applicant?
15. Does the applicant administer any methadone treatment? Yes No
If yes, describe treatment and controls used and indicate number of treatments during last 12 months (_____), next 12 months (____).
Is anesthesia (other than topical or by means of local infiltration) administered by either applicant or others?
16. Yes No
If yes, attached detailed explanation.
17. Does the applicant maintain any beds for overnight occupancy? Yes No
If yes, total number: _____
18. State number of X-ray machines owned or operated and whether they are used for diagnosis or treatment or both.
State by whom treatment is given and number of procedures: _____

19. Does the applicant own (wholly or in part), operate or administer any hospital, nursing home or other institution where medical services are customarily rendered? Yes No

If yes, give details, including name, location, size and number of beds. _____

20. State sources and amounts of total revenue:

Source	Amount Last Policy Year	Ext. Amount This Policy Year
a. Charitable Contributions	\$ _____	\$ _____
b. Government Funding	\$ _____	\$ _____
c. Fee for Services	\$ _____	\$ _____
d. _____	\$ _____	\$ _____
e. _____	\$ _____	\$ _____
TOTAL GROSS REVENUE:	\$ _____	\$ _____

21. Number of patient encounters last 12 months (____) and/or patient tests carried out (____).

(NOTE: "Patient encounters" refers to number of *visits* – not number of patients.)

22. Number of estimated patient encounters next 12 months (____) and/or patient tests carried out (____).

(NOTE: "Patient encounters" refers to number of *visits* – not number of patients.)

23. If applicant has a training school, complete the following.

Specify profession for which students are being trained	Max. No. of students per session	No. of sessions per year	% of Time involved in clinical setting	Number of students	Qualifications of faculty (eg. MD, RN, PhD)
_____	_____	_____	_____	_____	_____

24. If applicant is an ambulance service, please complete the following.

Number of Ground Ambulances _____ Number of Emergency Calls (per year) _____
 Number of Air Ambulances _____ Number of non-Emergency Calls (per year) _____
 Radius of Services _____

25. Give Professional Liability Coverage for last five years for the firm:

Carrier	Limit	Deductible	Premium	Expiration (Mo/Day/Yr)

If expiring insurance is a claims made policy, what is the retroactive date? _____

26. Is the applicant currently insured under a Commercial General Liability Policy? Yes No

If yes, please give details:

Insurance Company	Type of Coverage	Limits BI	Limits PD	From	To
_____	_____	_____	_____	_____	_____

27. Has any application for Professional Liability Insurance made on behalf of the firm, any predecessors in business or present partners ever been declined or has the insurance ever been cancelled or renewal refused? Yes No

If yes, please give details: _____

28. Has any claim ever been made against the applicant or any persons named in question 1? Yes No

If yes, how many? _____

Please attach currently valued company loss runs for the past 5 years and details stating:

1) Date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition

29. Is the applicant aware of any circumstances which may result in any claim against the applicant or any persons named in question 1? Yes No

If yes, how many? _____

Please attach currently valued company loss runs for the past 5 years and details stating:

1) Date when claim was made; 2) date the act giving rise to the claim was committed; 3) name of the claimant; 4) nature of the claim; 5) amount involved including reserves; and 6) final disposition

30. Has any insurer cancelled or refused to renew any similar insurance during the past five years? _____

31. Limits of Liability requested _____ Deductible _____

32. Desired term of policy: From _____ To _____

Representations

The Applicant declares that the above statement and representations are true and correct, and that no facts have been suppressed or misstated. All written statements and materials furnished to the Company, in conjunction with this application will be incorporated by reference into this application and made part hereof.

This application does not bind the Applicant to buy, or the Company to issue the insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued, and it will be attached to and made part of the policy. The undersigned Applicant declares that if the information supplied on this application changes between the dates of this application and the time when the policy is issued, the Applicant will immediately notify the company of such changes, and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance.

Signature of the Applicant

Title

Date

Producer