DENTAL ENTITY APPLICATION

I. ORGANIZATION INFORMATION

A. Entity Name:
(As stated in the Articles of Incorporation and all formal Entity/Clinic Names. Failure to provide complete names may void coverage.)

Entity Name _____

DBA, Fictitious Name, etc. _____

Federal Tax I.D. Number _____ National Provider Identifier (NPI) _____

Date Entity Formed (MM/YYYY) _____

E-Mail _____ Business Fax _____ Business Phone _____

B. If the above entity does business under any other name, please list all additional entity/clinic names.

Entity Name _____

Federal Tax I.D. Number _____ National Provider Identifier (NPI) _____

Date Entity Formed (MM/YYYY) _____

C. Type of Legal Entity: (Please put an "X" in the applicable spaces.)

- □ Professional Corporation - sole shareholder
  - □ Shared Limit Coverage with my MedPro RRG Risk Retention Group Individual Limits Policy **(No Employed or Contracted Dentist)**
  - □ Separate Entity Limits
- □ Professional Corporation - multiple shareholders
- □ Partnership or Professional Association
- □ Joint Venture
- □ Limited Liability Corporation (LLC)
- □ General Business Corporation
- □ Governmental (state, local or federal)
  - □ Not-For-Profit Clinic
  - □ For-Profit Clinic
- □ Other (Please explain) _____

D. Type of Organization: (Please put an "X" in the applicable spaces.)

- □ Private Practice Dental Office
- □ Administrative, billing and management entity
- □ Dental School
- □ Managed Care Organization/Managed Services Organization
- □ Non Profit Clinic
- □ Governmental Clinic
- □ Veterans Administration/Military Clinic
- □ Prison/Penitentiary
- □ Short Term Correctional Facility
- □ Licensed Dental Surgical Center
  - □ JCAHO / AAAHC Approved
- □ Mobile Dental Practice
- □ Nursing Home Based Practice
- □ Dental Laboratory
- □ Pharmacy
- □ Other (Please explain) _____

E. Is this entity associated with a current MedPro RRG Risk Retention Group insured? □ Yes □ No

(If yes, please provide the individual, corporation or partnership policy and group number if known.)

Policy Number _____ Group Number _____

I. ORGANIZATION INFORMATION (CONTINUED)

F. Practice Location(s):
(Please list principal location first. Combined percentage of practice for all locations must total 100% and cannot be of equal values.)

1. Primary Location:

% of Practice _____

Number and Street _____ Suite _____

City _____ State _____ County _____ Zip Code _____

2. Additional Location:

% of Practice _____

Number and Street _____ Suite _____

City _____ State _____ County _____ Zip Code _____

G. In which state(s) is this entity authorized to do business?

State of Incorporation _____

Certificate(s) of Authority _____

H. Preferred Billing and Correspondence Address:

□ Location Number _____ (From Question F. above) □ Other (please enter below)

Number and Street _____ Suite _____

City _____ State _____ Zip Code _____

II. GENERAL INFORMATION

A. Does the entity own or share ownership in a hospital, nursing home, clinic or other health care facility? □ Yes □ No

If yes, please explain _____

B. Are you aware if any former employee(s):

1. Has ever been the subject of disciplinary investigative proceedings or a reprimand by a Governmental Licensure Board or administrative agency, hospital or professional association? □ Yes □ No

   If yes, please provide the individual name(s), explanation and date(s).

   Individual Name(s) _____ Explanation _____ (MM/YYYY) _____

2. Has ever been indicted for, charged with, or convicted of, any act committed in violation of any law or ordinance, other than traffic offenses, or had hospital privileges, DEA license, dental license, or Medicaid/Medicare privileges refused, denied, revoked, suspended, restricted, subject to a reprimand, placed on probation or voluntarily surrendered? □ Yes □ No

   If yes, please provide the individual name(s), explanation and date(s).

   Individual Name(s) _____ Explanation _____ (MM/YYYY) _____

3. Has ever had any professional liability insurance refused, cancelled or non-renewed by an insurance company? □ Yes □ No

   If yes, please provide the individual name(s), explanation and date(s).

   Individual Name(s) _____ Explanation _____ (MM/YYYY) _____

II. GENERAL INFORMATION (CONTINUED)

C. Does the entity use a collection agency which has the authority to file collection suits without your knowledge? □ Yes □ No

D. Does the entity own or operate any laboratory? □ Yes □ No

If yes, is the laboratory providing services solely for your patients? □ Yes □ No

If no, please explain _____

E. Will the entity be performing activities that will be covered by another professional liability policy? □ Yes □ No

If yes, state practice name, location and insurer name:

Practice Name _____

Location _____

Name of Insurer _____

F. Has the entity performed any contract work for or entered into any contract or agreement (written or oral) with any Entity/City/County/State/Federal Agency/Clinic including providing care at correctional facilities, prisons, mental health facilities, veterans administration, university, military, indigent care or children's clinics, etc.? □ Yes □ No

If yes, please explain _____

G. Is general anesthesia administered outside of a hospital, JCAHO or AAAHC approved facility? □ Yes □ No

If yes, please answer the following:

1. Is scheduled preventative maintenance performed on all biomedical equipment each year by a qualified biomedical technician? □ Yes □ No

   If no, please explain _____

2. Does the entity have a dental services review committee? □ Yes □ No

   If no, please explain _____

3. Does the recovery room provide full time observation by a qualified health care provider? □ Yes □ No

   If no, please explain _____

III. LOSS INFORMATION

Please complete the Loss Information Supplement for each written request, incident, claim or suit involving former or present partners, members of the corporation, and any former or present employee or independent contractor of the corporation, partnership or organization.

Report Professional Liability and Malpractice related matters. (Including, but not limited to Board complaints, etc...)

For questions B and C below, report all matters that might reasonably lead to a claim or suit being brought against you even if you believe the claim or suit would be without merit.

A. Is your organization or any of your employees/contractors involved now or have ever been involved in a claim or suit arising out of the rendering or failure to render professional services? □ Yes □ No

If **yes**, how many? _____

B. Is your organization or any of your employees/contractors aware of any complication, incident or adverse outcome resulting in injury or death that might reasonably result in a claim or suit? This includes but is not limited to the following: □ Yes □ No

-Cancer -Death -Permanent Neurological Injury -Permanent Nerve Injury

If **yes**, how many? _____

C. In the last 12 months, has your organization or any of your employees/contractors received a written request from an attorney for treatment records concerning any of your current or former patients that might reasonably result in a claim or suit? □ Yes □ No

If **yes**, how many? _____

IV. ROSTER OF STAFFING INFORMATION

Please identify all owners, employed and contracted individuals within your organization and provide information concerning each member in each category listed below.

	1. Last name first, then first name and middle initial (i.e. Smith, John G.)	2. Degree	3. Specialty #1-18 (Refer to Key below)	4. (S) Shareholder (P) Partner (E) Employee (IC) Independent Contractor	5. Individual Status A,B,C,D or E (Refer to Key below)	6. MedPro RRG Risk Retention Policy #
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2.						
3.						
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16.						

Use the following key for:

Specialty: (column 3)

1. General Dentist
2. Oral and Maxillofacial Surgeon
3. Orthodontist
4. Pediatric Dentist
5. Periodontist
6. Prosthodontist
7. Endodontist
8. Dental Anesthesiologist
9. Pain Management
10. Physician
11. Dental Assistant
12. Dental Hygienist
13. Office Manager
14. Dental Lab Technician
15. Nurse Anesthetist / CRNA
16. RN / LPN
17. X-Ray Technician
18. Other (Specify job desc. in section IX)

Individual Status: (column 5)

A. Previous Individual MedPro RRG Risk Retention Group insured requesting Individual MedPro RRG Risk Retention Group coverage.
B. Current Individual MedPro RRG Risk Retention Group insured.
C. Requesting Individual MedPro RRG Risk Retention Group coverage.
D. Applying for coverage elsewhere or covered elsewhere.
E. Shared Limit Coverage - Including Allied Health Care Professionals.

***Note: Include all applicant(s), all healthcare provider(s) and non-healthcare owner(s).**

If Entity coverage is provided, it will include Allied Health Care Professionals, other than physicians or dentists, as Additional Insureds as defined by the Shared Limit Additional Insured Endorsement.

****If any of the Dentists who are corporation shareholders, employees and independent contractors listed on the roster above are not currently insured with MedPro RRG Risk Retention Group, please complete the Non-Insured Supplement.**

V. COVERAGE INFORMATION

A. Coverage Desired:

- □ Occurrence
- □ Claims-Made coverage without Prior Acts coverage
- □ Claims-Made coverage with Prior Acts coverage
- □ Convertible Claims-Made coverage with Prior Acts coverage

B. Requested Coverage Effective Date:

From (MM/DD/YYYY) _____ 12:01 a.m. To (MM/DD/YYYY) _____ 12:01 a.m.

Annual policy term will begin and end on the same month and day.

C. The Retroactive Date shown on your current Claims-Made policy (MM/DD/YYYY) _____ 12:01 a.m.
(This date is not required for Occurrence or Claims-Made without Prior Acts policies)

D. List all previous professional liability insurers in the last ten years:

1. Current Insurer: _____ Current Premium _____

□ Occurrence □ Claims-Made From (MM/DD/YYYY) _____ to (MM/DD/YYYY) _____

2. Previous Insurer: _____

□ Occurrence □ Claims-Made From (MM/DD/YYYY) _____ to (MM/DD/YYYY) _____

3. Previous Insurer: _____

□ Occurrence □ Claims-Made From (MM/DD/YYYY) _____ to (MM/DD/YYYY) _____

E. Please explain any gaps in coverage in the past ten years. _____

F. If 'Occurrence' or 'Claims-Made coverage without Prior Acts coverage' was selected as the Coverage Desired and the most recent prior coverage was issued on a Claims-Made basis, please complete one of the following:

- □ An extended reporting endorsement (tail coverage) has been purchased.
- □ An extended reporting endorsement has not and will not be purchased.

I **will not** purchase tail coverage (reporting endorsement) from my current insurer where I am insured under a Claims-Made policy. I realize that my failure to purchase such coverage from my current insurer will result in an uninsured exposure for any claims which may arise as result of professional services rendered while insured by my current insurer's policy. I understand that the policy, for which I am applying for with MedPro RRG Risk Retention Group, if offered, will not provide prior acts coverage.

Initial Here

Claims-Made coverage is limited generally to liability for injuries for which claims are first made during the policy period, for services rendered between the retroactive date and expiration date of the policy. Please contact your agent should you have any questions pertaining to the differences between Claims-Made and Occurrence coverage or the additional expense associated with "extension contract" or "tail coverage".

G. Limits Desired: _____ Per Occurrence/Per Claim Made _____ Annual Aggregate

VI. SUBSCRIBER AGREEMENT

I understand that if my application for insurance is accepted by MedPro RRG Risk Retention Group ("MEDPRO RRG"), I will be a subscriber ("Subscriber") of MEDPRO RRG and, by my signature below, I hereby acknowledge and agree that the below provisions of this Section VI, including the Power of Attorney, ("Subscriber Agreement") constitute the charter of MEDPRO RRG and that the subscribers to MEDPRO RRG from time to time shall together comprise the reciprocal insurer, which shall operate through its Attorney-in-Fact as provided in this Subscriber Agreement as a risk retention group in accordance with federal law and as a risk retention group in the form of a reciprocal captive insurer in accordance with District of Columbia law.

In consideration of similar agreements executed or to be executed by other subscribers and of the benefits of the exchange of such agreements and of the terms of this Subscriber Agreement, I agree to the following terms and conditions.

1. **Appointment and Powers and Duties of Attorney-In-Fact.** Subscriber agrees to the appointment of MedPro Risk Retention Services, Inc., an Indiana corporation ("Attorney-in-Fact"), as the Attorney-in-Fact for MEDPRO RRG to carry out the purposes and objectives set forth in this Subscriber Agreement and to carry out all business on behalf of MEDPRO RRG and the subscribers thereto. Subscriber also agrees to the appointment of the Board of Directors of the Attorney-in-Fact as the Subscribers' Advisory Committee for MEDPRO RRG. Attorney-in-Fact is vested with all necessary power and authority to act on behalf of MEDPRO RRG and the subscribers thereto, including conducting the affairs of MEDPRO RRG, managing and operating (directly or through contract with third parties (including affiliates of Attorney-in-Fact)) MEDPRO RRG for the benefit of the subscribers, and causing the issuance and exchange of indemnity, insurance or reinsurance contracts with other subscribers.
2. **Limitations of Liability**.
   a. The financial liability of Subscriber shall be limited to the amount of annual premiums on any contracts of indemnity, insurance or reinsurance due from Subscriber, provided, however, that all contracts of indemnity, insurance or reinsurance shall contain a "limit of liability" and in the event it is determined that Subscriber's liability on a claim under said contract of indemnity, insurance or reinsurance exceeds the limit of liability, such excess amount shall be the sole and complete responsibility of Subscriber.
   b. Should any suit, legal proceeding or other action be brought against Attorney-in-Fact resulting from or arising out of Subscriber's obligation on any contract of indemnity, insurance or reinsurance that Subscriber may enter into, then and in that event, any and all judgments entered against Attorney-in-Fact in that capacity shall be deemed a legal judgment against Subscriber.
3. **Maintenance and Distribution of Surplus.** Attorney-in-Fact shall cause MEDPRO RRG to maintain surplus in an amount sufficient to provide for the financial integrity of MEDPRO RRG and in an amount satisfactory to the District of Columbia Department of Insurance, Securities and Banking. In no event, however, shall Attorney-in-Fact be required to contribute its own assets or the assets of any affiliate to MEDPRO RRG.
   a. Subscriber authorizes Attorney-in-Fact to accrue for the benefit of MEDPRO RRG and the subscribers net income and savings realized from the exchange of contracts of indemnity, insurance or reinsurance hereunder and the management of MEDPRO RRG and its assets.
   b. Subject to the laws of the District of Columbia, if MEDPRO RRG is dissolved by Attorney-in-Fact, Attorney-in-Fact shall, after the full satisfaction of all liabilities and surplus notes of MEDPRO RRG from MEDPRO RRG's assets, pay each subscriber then insured an equitable share of all remaining assets, which payment shall be in full satisfaction of all rights and interests of such subscribers. Amounts to be paid to subscribers shall be distributed on an equitable basis as determined by Attorney-in-Fact.
4. **Term of Subscriber Agreement.**
   a. This Subscriber Agreement shall have no fixed term and begins with the commencement of the policy period of any contract of indemnity, insurance or reinsurance issued hereunder to Subscriber and ends upon cancellation or other termination of such contract of indemnity, insurance or reinsurance or upon replacement of this Subscriber Agreement by a modified subscriber agreement provided by Attorney-in-Fact. The period of subscription shall not include any period of coverage under extended reporting policies or extended reporting or tail coverage endorsements.
   b. Subscriber agrees that this Subscriber Agreement is expressly limited to the uses and purposes herein expressed and to no other. This Subscriber Agreement may be terminated by Subscriber or by Attorney-in-Fact upon 30 days written notice. The Subscriber's appointment of Attorney-in-Fact and Subscriber's obligations and authorizations under this Subscriber Agreement shall survive the termination of this Subscriber Agreement until any and all claims involving the indemnity, insurance or reinsurance contracts of the Subscriber and any and all other matters existing between the Subscriber and MEDPRO RRG, the Attorney-in-Fact or with third parties have been settled or satisfied. Subscriber agrees that the Attorney-in-Fact shall have the authority and ability to perform all duties and carry out all obligations during any extended reporting or tail coverage endorsements during the term of this Subscriber Agreement or after termination.
   c. After termination of this Subscriber Agreement, Subscriber shall have no rights to participate in any distribution of assets upon dissolution of MEDPRO RRG.
5. **Replacement of Attorney-in-Fact.** Attorney-in-Fact may resign as Attorney-in-Fact upon designation by Attorney-in-Fact of a successor attorney-in-fact and 60 days written notice to existing subscribers. Any such successor attorney-in-fact shall have all the powers, rights and duties provided for in this Subscriber Agreement, and this Subscriber Agreement shall remain in full force and effect with such successor attorney-in-fact.
6. **Principal Office.** The principal office of MEDPRO RRG shall be maintained in the District of Columbia or at such other place as designated by Attorney-in-Fact.
7. **Limitation of Liability of Attorney-in-Fact.** Subscriber agrees that no officer, director, or employee of Attorney-in-Fact shall be personally liable to MEDPRO RRG or its subscribers for any breach of duty owed to MEDPRO RRG or its subscribers, provided however that this provision shall not relieve an officer, director or employee from liability for any breach of duty based on an act or omission (a) in breach of such person's duty of loyalty to MEDPRO RRG and its subscribers; (b) not done in good faith or involving a knowing violation of law; or (c) resulting in receipt by such person of an improper personal benefit. Such officers, directors and employees of Attorney-in-Fact shall be entitled to indemnification and advancement of expenses subject to the same exceptions recited above.
8. **Nature of MEDPRO RRG.** Subscriber acknowledges that MEDPRO RRG is a risk retention group organized in the District of Columbia as a reciprocal captive insurer and as such its contracts of indemnity, insurance or reinsurance are not subject to all state insurance laws and regulations. Further, state insolvency or guarantee funds are not available to risk retention groups, like MEDPRO RRG. Subscriber also acknowledges that MEDPRO RRG is a reciprocal organization under which each subscriber exchanges insurance obligations with the other subscribers through an attorney-in-fact.
9. **Governing Law.** This Subscriber Agreement shall be governed by and interpreted according to the laws of the District of Columbia without giving effect to the conflict or choice of law provisions of that or any other jurisdiction.

VII. STATE STATUTORY REQUIREMENT

Under the laws of your state, it may be a criminal offense to knowingly provide false, incomplete, or misleading information to an insurance company. Penalties for fraud may result in one or more of the following: imprisonment, fines or denial of insurance benefits.

Please initial the statements below.

Mandatory: All applicants must read and initial the following:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Initial Here

VIII. PLEASE READ AND SIGN

I hereby declare that the above statements and particulars, or any statements and particulars made in any and all documents, applications, supplemental pages or other attachments (**hereinafter "Attachments**") for the purposes of my initial or renewal application, are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application, and any **Attachments**, shall be the basis of the contract with MedPro RRG Risk Retention Group ("Company"). I agree to notify the Company if there is any future material change in any answer to this application, or its **Attachments**, including without limitation, any change in my professional specialty, affiliation, or working arrangement with any other dentist, physician, firm, or professional association.

I understand that any material misrepresentation or omission made by me on this application may act to render any contract of insurance null and without effect or provide the Company with the right to rescind it. By making this application, I am not relying upon any oral or written representation that coverage has or will be extended to me or that a policy of insurance will be issued.

I further understand and agree that I have no right to demand or expect coverage until the Company has: (1) received my completed application; (2) offered me a premium quote; and (3) received, as a precondition to coverage, the total premium due or, if the Company has agreed to finance the premium, the first installment due. In addition, I understand that if I pay my premium or first installment by check, electronic transfer or money order, it shall not be considered as "received" by the Company until it has been honored by the bank.

I agree that **if I fail to comply with these terms I will have no coverage for any claim** under any policy of insurance for which I am applying.

I also understand that the Company may wish to contact persons, hospitals, schools, employers, insurance agents, professional liability insurers or other entities to verify and/or ascertain information regarding my credentials and background both prior to and if issued, after the issuance of a contract of insurance. Therefore, I hereby instruct any such person, hospital, school, employer, insurance agent, professional liability insurer or other entity to release to the Company any information regarding me, which the Company, in good faith, believes to be applicable and pertinent to this application and if issued, the contract of insurance issued hereunder.

Application must be signed by a President, Chief Executive Officer, or other Officer or Partner of a PC/PA or the Office Administrator or equivalent Authorized Representative.

Authorized Representative/Subscriber's Signature _____ Date Signed _____

Type or Print Name _____ Title _____

IX. ADDITIONAL INFORMATION

Attach a separate piece of paper if additional space is needed.

DENTAL LOSS INFORMATION SUPPLEMENT

Please make copies if additional forms are needed.

Applicant's Name _____

Note: Additional documentation may be requested at the Company's discretion.

A. Is the matter related to ◯ A, ◯ B or ◯ C (if applicable) from the Loss Information Section? (Check only one)

B. Patient/Claimant Information:

_____ _____ _____

Last Name **First Name** **Age**

C. Date of treatment and/or surgery, which led, or could lead, to allegations against you: (MM/YYYY) _____

D. Date notice received (if applicable): (MM/YYYY) _____

E. Has this matter been reported to your current or former insurer? ◯ Yes ◯ No

If yes, date reported to your current or former insurer? (MM/YYYY) _____

Current or former insurer name _____

If no, please explain _____

F. Name of all other doctor(s), hospital(s) or health care provider(s), if any, involved:

_____

_____

G. Current status: ◯ Open ◯ Closed

If open, indicate dollar value established by insurer: $_____

If closed,

1. Date of closing (MM/YYYY): _____
2. Was a payment made? ◯ Yes ◯ No
   a. If yes, did you consent to the settlement? ◯ Yes ◯ No
   b. Total amount of settlement or award: $_____
   c. Total amount of settlement or award paid on your behalf: $_____

H. Nature of allegations or potential allegations:

Condition Treated _____

Treatment Provided _____

Alleged Negligence _____

Alleged Injury _____

Please provide a narrative description of all relevant facts, including but not limited to your involvement in the treatment and/or surgery:

_____

_____

_____

_____

DENTAL ANESTHESIA SUPPLEMENT

Applicant's Name _____

A. If you perform conscious sedation and/or general anesthesia, do you administer sedation for medical procedures? ◯ Yes ◯ No

B. Please indicate who administers Conscious Sedation:

- ☐ I Do
- ☐ Oral Surgeon
- ☐ Nurse Anesthetist/CRNA
- ☐ Other (Please explain) _____
- ☐ RN/LPN
- ☐ Dental Anesthesiologist
- ☐ MD/DO Anesthesiologist

Where is Conscious Sedation performed?

- ☐ In My Office
- ☐ Hospital
- ☐ Licensed JCAHO or AAAHC Approved Surgical Center
- ☐ Other (Please explain) _____

C. Please indicate who administers General Anesthesia:

- ☐ I Do
- ☐ Oral Surgeon
- ☐ Nurse Anesthetist/CRNA
- ☐ Other (Please explain) _____
- ☐ RN/LPN
- ☐ Dental Anesthesiologist
- ☐ MD/DO Anesthesiologist

Where is General Anesthesia performed?

- ☐ In My Office
- ☐ Hospital
- ☐ Licensed JCAHO or AAAHC Approved Surgical Center
- ☐ Other (Please explain) _____

D. Do you accept referrals for the administration of anesthesia? ☐ Yes ☐ No

E. Do you prescribe Benzodiazepine type oral sedation agents? (Halcion, Triazolam, Ativan, Valium or similar anesthetic agent) ☐ Yes ☐ No

If yes, do you exceed the maximum recommended dosage ("MRD")? ☐ Yes ☐ No

If yes, are you trained and is your office prepared to administer reversal agents such as flumazinil intravenously? ☐ Yes ☐ No

F. How often do you update health histories?

Every: ☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ Other _____

G. Is your office certified for general anesthesia by a state organization? ☐ Yes ☐ No

If yes, date of issuance: (MM/YYYY) _____

H. If conscious sedation or general anesthesia is performed outside of a hospital, JCAHO or AAAHC approved facility, how often do you and your staff participate in simulated emergency training?

Every: ☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ Other _____

I. Are you or the individual administering the sedation, certified in one or more of the following? ☐ Yes ☐ No

If yes, please mark the applicable boxes: ☐ CPR ☐ ACLS ☐ ATLS ☐ PALS

J. Do you utilize the following equipment? (Please "X" equipment used)
Checking the box indicates this equipment will be available during all anesthesia procedures performed outside a hospital, JCAHO or AAAHC approved facility.

Basic Airway Equipment:

- ☐ Oral and Nasopharyngeal Airways
- ☐ Full Face Mask Resuscitator
- ☐ Endotracheal Tubes (adult/child size)
- ☐ Laryngoscope
- ☐ Direct Current Defibrillator
- ☐ Tracheostomy/Coniotomy Equipment
- ☐ Sphygmomanometer/Stethoscope
- ☐ Electrocardiographic Monitoring Equipment
- ☐ Pulse Oximeter
- ☐ CO2 Monitor
- ☐ Internal/External Temperature Monitor
- ☐ Portable Suction
- ☐ Capnography
- ☐ Auxiliary Lighting
- ☐ Emergency Pharmaceutical Kit
- ☐ Fail safe mechanisms on anesthesia machines

K. If you are hosting anesthesia provider(s), outside of a hospital, JCAHO or AAAHC approved facility, have you and will you ensure those anesthesia provider(s) have:

The equipment indicated (checked) above? ☐ Yes ☐ No

Professional liability limits equal to or greater than your policy limits? ☐ Yes ☐ No