POLICY	NUMBER

OMPANY LISE ONLY

BROKERAGE FIRM/AGE	NCY NAME		
CITY, STATE, AND ZIP	CODE		
BROKER/AGENT NAME			
PHONE	FAX	E-MAIL	
CONTACT INFORMATION			
APPLICANT NAME (LEG	AL CORPORATION NAME)		
MAILING ADDRESS		COUNTY	
STREET ADDRESS (IF D	IFFERENT)		
CONTACT PERSON NAM	<u> </u>	TITLE	
		TITLE	
This date cannot be ear REQUESTED COVERAGE EX	BUSINESS FAX FFECTIVE DATE (12:01 AM): lier than the expiration date of your curr KPIRATION DATE (12:01 AM):	RESIDENCE PHONE	
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WEBSITE ADDRESS REQUESTED COVERAGE EI This date cannot be ear REQUESTED COVERAGE EX Annual policy terms wil COVERAGES, LIMITS AI COVERAGE (*) OFESSIONAL LIABILITY	BUSINESS FAX FFECTIVE DATE (12:01 AM): dier than the expiration date of your curr XPIRATION DATE (12:01 AM): I begin and end on the same month and on	RESIDENCE PHONE ent policy. day. POLICY TYPE	(PRIMARY COVERAGE) □ NONE □ \$5,000 □ \$10,000 □ \$25,000 □ \$50,000
WEBSITE ADDRESS REQUESTED COVERAGE EI This date cannot be ear REQUESTED COVERAGE EX Annual policy terms will COVERAGES, LIMITS AI COVERAGE (*)	BUSINESS FAX FFECTIVE DATE (12:01 AM): lier than the expiration date of your curr KPIRATION DATE (12:01 AM): I begin and end on the same month and on	RESIDENCE PHONE ent policy. day. POLICY TYPE	(PRIMARY COVERAGE) □ NONE □ \$5,000 □ \$10,000
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	GENERAL INFORMATION								
Α.	TYPE OF LEGAL ENTITY (Please put an "X" in	the applicable space	ces):						
	Professional Corporation								
	Partnership or Professional Association								
	☐ Joint Venture								
	Limited Liability Corporation (LLC)								
	Other (Please Explain):								
	ENTITY OWNERSHIP (Please put an "X" in th	e applicable spaces):						
	Physician Owned								
	☐ Hospital Owned								
	☐ Independently Owned								
	Other (Please Explain):								
	TAX STATUS (Please put an "X" in the applica	ible spaces):							
	For Profit								
	☐ Not For Profit								
	Other (Please Explain):								
	LICENSES HELD BY YOUR FACILITY:								
	CERTIFICATIONS/ACCREDITATIONS HELD B								
	☐ CMS ☐ JCAHO ☐ AAAHC ☐ IAC	ACR IMQ	OTHER:						
	PLEASE PROVIDE A COPY OF YOUR CERTIFICA	TE/ACCREDITATION I	NCLUDING ANY RECO	OMMENDATIONS MADE.					
	HOW MANY IMAGING CENTER LOCATIONS D	O YOU HAVE?							
	IF YOU HAVE MULTIPLE LOCATIONS, ARE ALL I	OCATIONS ACCREDIT	TED/CERTIFIED?		☐YES ☐ NO				
	IF NO, PLEASE PROVIDE DETAILS:								
	MEDICAL DIRECTOR:								
	NAME OF MEDICAL DIRECTOR								
	PHONE NUMBER EM/	AIL							
	ANNUAL PAYROLL								
	TOTAL ANNUAL PAYROLL:		TOTAL PROJECTED A	ANNUAL RECEIPTS:					
	ARE THERE ANY PLANS FOR MERGERS OR AC	OUISITIONS DURI	NG THE NEXT 12 M	ONTHS?	☐ YES ☐ NO				
	IF YES, PLEASE EXPLAIN:								
,	THE CINC CENTER OPERATIONS								
	IMAGING CENTER OPERATIONS INDICATE THE TOTAL NUMBER OF READS/SE	PVICES							
•	PERFORMED AT YOUR FACILITY DURING		HS:						
	YOU EXPECT TO PERFORM AT YOUR FACIL								
	INDICATE THE TYPES OF READS OR SERVICES PROVIDED:								
	CURRENT (LAST 12 MONTHS) PROJECTED (NEXT 12 MONT								
			TOTAL REVENUE	READS/SERVICES	TOTAL REVENU				
	UTILIZATION	READS/SERVICES							
	UTILIZATION GENERAL RADIOGRAPHY (X-RAY)	READS/SERVICES							
		READS/SERVICES							
	GENERAL RADIOGRAPHY (X-RAY)	READS/SERVICES							
	GENERAL RADIOGRAPHY (X-RAY) COMPUTERIZED TOMOGRAPHY (CT)	READS/SERVICES							
	GENERAL RADIOGRAPHY (X-RAY) COMPUTERIZED TOMOGRAPHY (CT) MAGNETIC RESONANCE IMAGING (MRI)	READS/SERVICES							
	GENERAL RADIOGRAPHY (X-RAY) COMPUTERIZED TOMOGRAPHY (CT) MAGNETIC RESONANCE IMAGING (MRI) POSITRON EMISSION TOMOGRAPHY (PET)	READS/SERVICES							

i.e. ARE YOU ADDING OR DISCONTINUING ANY SERVICES?) F YES, PLEASE DESCRIBE:	☐YES ☐NO
HAVE ANY SERVICES BEEN DISCONTINUED DURING THE LAST <u>24</u> MONTHS? F YES, PLEASE DESCRIBE:	YES NO
DOES YOUR FACILITY PROVIDE? INITIAL READS OVER-READS / SECOND READS EXTERNAL PEER REVIEW	SERVICES
WHAT TYPE OF CONTRAST MEDIA IS BEING ADMINISTERED?	
□ IONIC	<u></u> %
ARE THERE PROTOCOLS FOR USE OF CONTRAST MEDIA? IF NO, PLEASE EXPLAIN:	☐YES ☐ NO
IS A PHYSICIAN PRESENT DURING THE INJECTION OF CONTRAST MEDIA? IF NO, PLEASE EXPLAIN:	☐ YES ☐ NO
DO YOU HAVE WRITTEN PROTOCOLS FOR HANDLING ALLERGIC REACTIONS INCLUDING CARDIAC OR RESPIRATORY ARREST?	YES NO
IF NO, PLEASE EXPLAIN:	
DOES YOUR FACILITY PROVIDE MOBILE RADIOLOGY SERVICES? IF YES, WHAT PERCENTAGE OF YOUR OVERALL SERVICES DOES THIS REPRESENT?	□YES □NO
·	
DOES YOUR ORGANIZATION USE TELERADIOLOGY SERVICES FOR INTERPRETATION OF READS?	YES NO
DOES YOUR ORGANIZATION PROVIDE ANY TELERADIOLOGY SERVICES TO OTHER ORGANIZATIONS?	YES NO
IF YOU ANSWERED YES TO EITHER QUESTION K. OR L. ABOVE, PLEASE COMPLETE THE FOLLOWING: 1. ARE YOU COMPLIANT WITH THE AMERICAN COLLEGE OF RADIOLOGY (ACR) TECHNICAL STANDARDS FOR ELECTRONIC PRACTICE OF MEDICAL IMAGING?	☐YES ☐NO
If you answered no, describe the areas of non-compliance:	
2. IS YOUR FACILITY EQUIPPED WITH A DIGITAL PAC RADIOLOGY SYSTEM?	YES NO
3. ARE FILMS TRANSMITTED INTERSTATE?	☐YES ☐NO
4. DO ANY "READING" PHYSICIANS RESIDE OUTSIDE OF THE U.S. AND ITS TERRITORIES?	YES NO
5. PLEASE PROVIDE ADDITIONAL COMMENTS IF YOU WOULD LIKE TO EXPLAIN YOUR USE OF TELERADIOLOGY SI	ERVICES:
IN SOME SITUATIONS, YOU MAY BE ASKED TO COMPLETE A TELERADIOLOGY SUPPLEMENTAL DO YOU PROVIDE ANY MEDICAL PROFESSIONAL SERVICES TO NON-PATIENTS (MEDICAL, LABORATORY	-
DO YOU PROVIDE ANY MEDICAL PROFESSIONAL SERVICES TO NON-PATIENTS (MEDICAL, LABORATORY	
DO YOU PROVIDE ANY MEDICAL PROFESSIONAL SERVICES TO NON-PATIENTS (MEDICAL, LABORATORY PHARMACY ETC.)?	
DO YOU PROVIDE ANY MEDICAL PROFESSIONAL SERVICES TO NON-PATIENTS (MEDICAL, LABORATORY PHARMACY ETC.)? IF YES, PLEASE EXPLAIN AND PROVIDE ASSOCIATED RECEIPTS OR OUTPATIENT VISITS: HAVE YOU OR WILL YOU PROVIDE RESEARCH ACTIVITIES FOR PHARMACEUTICALS, SURGERY,	YES NO
DO YOU PROVIDE ANY MEDICAL PROFESSIONAL SERVICES TO NON-PATIENTS (MEDICAL, LABORATORY PHARMACY ETC.)? IF YES, PLEASE EXPLAIN AND PROVIDE ASSOCIATED RECEIPTS OR OUTPATIENT VISITS: HAVE YOU OR WILL YOU PROVIDE RESEARCH ACTIVITIES FOR PHARMACEUTICALS, SURGERY, BIOMEDICAL EQUIPMENT OR PSYCHOTHERAPY?	YES NO
DO YOU PROVIDE ANY MEDICAL PROFESSIONAL SERVICES TO NON-PATIENTS (MEDICAL, LABORATORY PHARMACY ETC.)? IF YES, PLEASE EXPLAIN AND PROVIDE ASSOCIATED RECEIPTS OR OUTPATIENT VISITS: HAVE YOU OR WILL YOU PROVIDE RESEARCH ACTIVITIES FOR PHARMACEUTICALS, SURGERY, BIOMEDICAL EQUIPMENT OR PSYCHOTHERAPY? IF YES, PLEASE COMPLETE A SEPARATE RESEARCH SUPPLEMENTAL QUESTIONNAIRE.	YES NO
DO YOU PROVIDE ANY MEDICAL PROFESSIONAL SERVICES TO NON-PATIENTS (MEDICAL, LABORATORY PHARMACY ETC.)? IF YES, PLEASE EXPLAIN AND PROVIDE ASSOCIATED RECEIPTS OR OUTPATIENT VISITS: HAVE YOU OR WILL YOU PROVIDE RESEARCH ACTIVITIES FOR PHARMACEUTICALS, SURGERY, BIOMEDICAL EQUIPMENT OR PSYCHOTHERAPY? IF YES, PLEASE COMPLETE A SEPARATE RESEARCH SUPPLEMENTAL QUESTIONNAIRE. DO YOU HAVE THE FOLLOWING EQUIPMENT AT YOUR FACILITY:	YES NO
DO YOU PROVIDE ANY MEDICAL PROFESSIONAL SERVICES TO NON-PATIENTS (MEDICAL, LABORATORY PHARMACY ETC.)? IF YES, PLEASE EXPLAIN AND PROVIDE ASSOCIATED RECEIPTS OR OUTPATIENT VISITS: HAVE YOU OR WILL YOU PROVIDE RESEARCH ACTIVITIES FOR PHARMACEUTICALS, SURGERY, BIOMEDICAL EQUIPMENT OR PSYCHOTHERAPY? IF YES, PLEASE COMPLETE A SEPARATE RESEARCH SUPPLEMENTAL QUESTIONNAIRE. DO YOU HAVE THE FOLLOWING EQUIPMENT AT YOUR FACILITY: 1. CRASH CART WITH FULL CARDIAC LIFE SUPPORT CAPABILITIES AND NECESSARY IV FLUIDS? 2. DEFIBRILLATOR? 3. EKG?	YES NO YES NO YES NO YES NO
DO YOU PROVIDE ANY MEDICAL PROFESSIONAL SERVICES TO NON-PATIENTS (MEDICAL, LABORATORY PHARMACY ETC.)? IF YES, PLEASE EXPLAIN AND PROVIDE ASSOCIATED RECEIPTS OR OUTPATIENT VISITS: HAVE YOU OR WILL YOU PROVIDE RESEARCH ACTIVITIES FOR PHARMACEUTICALS, SURGERY, BIOMEDICAL EQUIPMENT OR PSYCHOTHERAPY? IF YES, PLEASE COMPLETE A SEPARATE RESEARCH SUPPLEMENTAL QUESTIONNAIRE. DO YOU HAVE THE FOLLOWING EQUIPMENT AT YOUR FACILITY: 1. CRASH CART WITH FULL CARDIAC LIFE SUPPORT CAPABILITIES AND NECESSARY IV FLUIDS? 2. DEFIBRILLATOR?	YES NO YES NO YES NO YES NO YES NO YES NO

NAME				
ADDRESS				
DO YOU HAVE WRITTEN F	OLICIES AND PROCEDURES TH	IAT ADDRESS:		
1. FORMALIZED WRITTEN	N PEER REVIEW PROCESS THAT IN	CLUDES RANDOM OVER	R-READS?	☐ YES ☐ NO
2. PROTOCOLS ON MATC	HING THE CORRECT PATIENT WIT	H THE CORRECT DIAGN	IOSTIC EXAMS?	☐YES ☐NO
3. FORMALIZED GUIDELI	NES RELATING TO THE COMMUNIC	CATION OF DIAGNOSTIC	SERVICES INCLUDING T	THE FOLLOWING:
A. COMMUNICATING RE	SULTS TO PATIENTS AND THEIR PHYS	SICIAN VIA LETTER OR PH	ONE CALLS?	☐YES ☐ NO
B. COMMUNICATING AB	NORMAL FINDINGS TO REFERRING PH	YSICIANS NOT ON YOUR	MEDICAL STAFF?	YES NO
C. COMMUNICATING MA	MMOGRAM RESULTS TO PATIENTS AN	ND THEIR REFERRING PHY	SICIAN WITHIN 30 DAYS?	☐ YES ☐ NO
D. COMMUNICATING RE	SULTS OF SELF-REFERRED PATIENTS	TO A PHYSICIAN WHEN C	LINICALLY INDICATED?	☐YES ☐ NO
E. ACTIVE RECALL OR R	EMINDER SYSTEM FOR REPEAT EXAMS	S?		YES NO
4. PROCEDURES FOR THE	ARCHIVING OF FILMS FOR A SPE	CIFIC PERIOD OF TIME	?	☐ YES ☐ NO
5. EMERGENCY TRANSFE	R PROTOCOLS?			☐ YES ☐ NO
6. WRITTEN AGREEMENT	WITH A HOSPITAL TO PROVIDE I	EMERGENT HIGHER LEV	'EL OF CARE?	☐ YES ☐ NO
7. EQUIPMENT SAFETY P	ROTOCOLS SUCH AS CALIBRATION	I, IDENTIFYING OPERAT	ING IRREGULARITIES, E	TC.? YES NO
8. PERIODIC TRAINING A	ND IN-SERVICE EDUCATION?			☐ YES ☐ NO
MEDICAL STAFF PLEASE PROVIDE THE INI	FORMATION REQUESTED BELON			
PLEASE PROVIDE THE INI IMPORTANT NOTE: IF CO' LIMITS AND DEDUCTIBLE	(If more room is needed VERAGE IS DESIRED FOR PHYS SCHEDULE) AND SECTION IV (l, please attach a sep ICIANS, PLEASE IND (THE SCHEDULE OF M	arate roster of Medical ICATE THAT ON SECTION IEDICAL PROFESSIONA	Staff) ON III (COVERAGES, ALS) OF THE IMAGING
PLEASE PROVIDE THE INI IMPORTANT NOTE: IF CO' LIMITS AND DEDUCTIBLE	(If more room is needed VERAGE IS DESIRED FOR PHYS SCHEDULE) AND SECTION IV (APPLICATION. ALSO COMPLETIN FOR EACH PHYSICIAN.	l, please attach a sep ICIANS, PLEASE IND (THE SCHEDULE OF M	arate roster of Medical ICATE THAT ON SECTI IEDICAL PROFESSIONA CIAN INDIVIDUAL PRO	Staff) ON III (COVERAGES, ALS) OF THE IMAGING DFESSIONAL LIABILITY
PLEASE PROVIDE THE INI IMPORTANT NOTE: IF CO' LIMITS AND DEDUCTIBLE CENTER SUPPLEMENTAL A	(If more room is needed VERAGE IS DESIRED FOR PHYS SCHEDULE) AND SECTION IV (APPLICATION. ALSO COMPLETI	l, please attach a sep ICIANS, PLEASE IND (THE SCHEDULE OF M	arate roster of Medical ICATE THAT ON SECTI IEDICAL PROFESSIONA CIAN INDIVIDUAL PRO	Staff) ON III (COVERAGES, ALS) OF THE IMAGING
PLEASE PROVIDE THE INI IMPORTANT NOTE: IF COV LIMITS AND DEDUCTIBLE CENTER SUPPLEMENTAL A INSURANCE APPLICATION	(If more room is needed VERAGE IS DESIRED FOR PHYS SCHEDULE) AND SECTION IV (APPLICATION. ALSO COMPLETIN FOR EACH PHYSICIAN. INDICATE IF THEY ARE A: MEMBER (M), PARTNER (P), SHAREHOLDER (S), EMPLOYEE (E), CONTRACTED PHYSICIAN	I, please attach a sep ICIANS, PLEASE IND (THE SCHEDULE OF M E A SEPARATE PHYSI PRIMARY LICENSE	arate roster of Medical ICATE THAT ON SECTION IEDICAL PROFESSION ICIAN INDIVIDUAL PRO INDICATE PRIMARY	Staff) ON III (COVERAGES, ALS) OF THE IMAGING DESSIONAL LIABILITY INDICATE THE NUMBER OF HOUR PER WEEK OR DAYS PER WEEK EACH PHYSICIAN WILL SPEND AT
PLEASE PROVIDE THE INI IMPORTANT NOTE: IF COV LIMITS AND DEDUCTIBLE CENTER SUPPLEMENTAL A INSURANCE APPLICATION	(If more room is needed VERAGE IS DESIRED FOR PHYS SCHEDULE) AND SECTION IV (APPLICATION. ALSO COMPLETIN FOR EACH PHYSICIAN. INDICATE IF THEY ARE A: MEMBER (M), PARTNER (P), SHAREHOLDER (S), EMPLOYEE (E), CONTRACTED PHYSICIAN	I, please attach a sep ICIANS, PLEASE IND (THE SCHEDULE OF M E A SEPARATE PHYSI PRIMARY LICENSE	arate roster of Medical ICATE THAT ON SECTION IEDICAL PROFESSION ICIAN INDIVIDUAL PRO INDICATE PRIMARY	Staff) ON III (COVERAGES, ALS) OF THE IMAGING DESSIONAL LIABILITY INDICATE THE NUMBER OF HOUR PER WEEK OR DAYS PER WEEK EACH PHYSICIAN WILL SPEND AT
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PLEASE PROVIDE THE INI IMPORTANT NOTE: IF COV LIMITS AND DEDUCTIBLE CENTER SUPPLEMENTAL A INSURANCE APPLICATION	(If more room is needed VERAGE IS DESIRED FOR PHYS SCHEDULE) AND SECTION IV (APPLICATION. ALSO COMPLETIN FOR EACH PHYSICIAN. INDICATE IF THEY ARE A: MEMBER (M), PARTNER (P), SHAREHOLDER (S), EMPLOYEE (E), CONTRACTED PHYSICIAN	I, please attach a sep ICIANS, PLEASE IND (THE SCHEDULE OF M E A SEPARATE PHYSI PRIMARY LICENSE	arate roster of Medical ICATE THAT ON SECTION IEDICAL PROFESSION ICIAN INDIVIDUAL PRO INDICATE PRIMARY	Staff) ON III (COVERAGES, ALS) OF THE IMAGING DESSIONAL LIABILITY INDICATE THE NUMBER OF HOUR PER WEEK OR DAYS PER WEEK EACH PHYSICIAN WILL SPEND AT
PLEASE PROVIDE THE INI IMPORTANT NOTE: IF CO' LIMITS AND DEDUCTIBLE CENTER SUPPLEMENTAL / INSURANCE APPLICATION PHYSICIAN'S NAME	(If more room is needed VERAGE IS DESIRED FOR PHYS SCHEDULE) AND SECTION IV (APPLICATION. ALSO COMPLETIN FOR EACH PHYSICIAN. INDICATE IF THEY ARE A: MEMBER (M), PARTNER (P), SHAREHOLDER (S), EMPLOYEE (E), CONTRACTED PHYSICIAN (C), OR ALL OTHER (AO)	I, please attach a sep ICIANS, PLEASE IND THE SCHEDULE OF M E A SEPARATE PHYSI PRIMARY LICENSE NUMBER	arate roster of Medical ICATE THAT ON SECTIC IEDICAL PROFESSIONA CIAN INDIVIDUAL PRO INDICATE PRIMARY SPECIALTY	Staff) ON III (COVERAGES, ALS) OF THE IMAGING DESSIONAL LIABILITY INDICATE THE NUMBER OF HOUR PER WEEK OR DAYS PER WEEK EACH PHYSICIAN WILL SPEND AT YOUR FACILITY
PLEASE PROVIDE THE INI IMPORTANT NOTE: IF CO' LIMITS AND DEDUCTIBLE CENTER SUPPLEMENTAL / INSURANCE APPLICATION PHYSICIAN'S NAME ARE EACH OF THE PHYSIC	(If more room is needed VERAGE IS DESIRED FOR PHYS SCHEDULE) AND SECTION IV (APPLICATION. ALSO COMPLETIN FOR EACH PHYSICIAN. INDICATE IF THEY ARE A: MEMBER (M), PARTNER (P), SHAREHOLDER (S), EMPLOYEE (E), CONTRACTED PHYSICIAN (C), OR ALL OTHER (AO)	I, please attach a sep ICIANS, PLEASE IND THE SCHEDULE OF M E A SEPARATE PHYSI PRIMARY LICENSE NUMBER	arate roster of Medical ICATE THAT ON SECTIC IEDICAL PROFESSIONA CIAN INDIVIDUAL PRO INDICATE PRIMARY SPECIALTY	Staff) ON III (COVERAGES, ALS) OF THE IMAGING DESSIONAL LIABILITY INDICATE THE NUMBER OF HOUR PER WEEK OR DAYS PER WEEK EACH PHYSICIAN WILL SPEND AT
PLEASE PROVIDE THE INI IMPORTANT NOTE: IF CO LIMITS AND DEDUCTIBLE CENTER SUPPLEMENTAL A INSURANCE APPLICATION PHYSICIAN'S NAME ARE EACH OF THE PHYSIC IF NO, HOW MANY ARE N	(If more room is needed VERAGE IS DESIRED FOR PHYS SCHEDULE) AND SECTION IV (APPLICATION. ALSO COMPLETIN FOR EACH PHYSICIAN. INDICATE IF THEY ARE A: MEMBER (M), PARTNER (P), SHAREHOLDER (S), EMPLOYEE (E), CONTRACTED PHYSICIAN (C), OR ALL OTHER (AO)	I, please attach a sep ICIANS, PLEASE IND THE SCHEDULE OF M E A SEPARATE PHYSI PRIMARY LICENSE NUMBER ACILITY BOARD CERT	arate roster of Medical ICATE THAT ON SECTIC IEDICAL PROFESSIONA CIAN INDIVIDUAL PRO INDICATE PRIMARY SPECIALTY IFIED?	Staff) ON III (COVERAGES, ALS) OF THE IMAGING DFESSIONAL LIABILITY INDICATE THE NUMBER OF HOUR PER WEEK OR DAYS PER WEEK EACH PHYSICIAN WILL SPEND AT YOUR FACILITY
PLEASE PROVIDE THE INI IMPORTANT NOTE: IF CO LIMITS AND DEDUCTIBLE CENTER SUPPLEMENTAL A INSURANCE APPLICATION PHYSICIAN'S NAME ARE EACH OF THE PHYSIC IF NO, HOW MANY ARE NO DO YOU HAVE ANY PHYSI IF YES, PLEASE EXPLAIN:	(If more room is needed VERAGE IS DESIRED FOR PHYS SCHEDULE) AND SECTION IV (APPLICATION. ALSO COMPLETI N FOR EACH PHYSICIAN. INDICATE IF THEY ARE A: MEMBER (M), PARTNER (P), SHAREHOLDER (S), EMPLOYEE (E), CONTRACTED PHYSICIAN (C), OR ALL OTHER (AO) CIANS PRACTICING AT YOUR FAOT BOARD CERTIFIED? CIANS ON STAFF THAT DO NOT JMBER OF HEALTH PROFESSION	I, please attach a sep ICIANS, PLEASE IND THE SCHEDULE OF M E A SEPARATE PHYSI PRIMARY LICENSE NUMBER ACILITY BOARD CERT	arate roster of Medical ICATE THAT ON SECTION ICAL PROFESSIONA CIAN INDIVIDUAL PRO INDICATE PRIMARY SPECIALTY TIPIED? RIVILEGES AT A HOSPI	Staff) ON III (COVERAGES, ALS) OF THE IMAGING DFESSIONAL LIABILITY INDICATE THE NUMBER OF HOUR PER WEEK OR DAYS PER WEEK EACH PHYSICIAN WILL SPEND AT YOUR FACILITY

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<u>IM</u> P	ORTANT NOTE: IF COVERAGE IS DESIRED FOR HI	EALTH PROFESSIO	NALS, OTHER THAN PH	YSICIANS, PLEASE	INDICATE
ON	SECTION III (COVERAGES, LIMITS AND DEDUCTI	BLE SCHEDULE) AN	ID SECTION V (THE SO	HEDULE OF MEDICA	AL
	FESSIONALS) OF THE IMAGING CENTER SUPPLEI MIT AN APPLICATION FOR EACH INDIVIDUAL TH			1115 COVERAGE IS	DESIKED,
	ALLIED PROFESSIONALS EXCEPT PHYSICIANS	# EMPLOYED	# VOLUNTEERS	# CONTRACTED	
	NURSE PRACTITIONERS				
	PHYSICIAN ASSISTANTS				
	LPNs / RNs				
	MEDICAL TECHNICIANS				
	RADIOLOGICAL TECHNICIANS (DIAGNOSTIC)				_
	RADIOLOGICAL TECHNICIANS (THERAPY)		1		_
	OTHERS (DESCRIBE)		1		4
					_
DO '	YOU SUPERVISE ANYONE OTHER THAN YOUR OW	N EMPLOYEES?		□YE	s 🗌 no
IF	YES, PLEASE DESCRIBE THE RESPONSIBILITY OF THE	INDIVIDUALS AND V	VHAT YOUR RELATIONSH	HIPS ARE TO THESE IN	NDIVIDUALS
_					
Α	LSO INDICATE, BY TYPE OF MEDICAL PROFESSIONAL,	THE NUMBER OF INC	DIVIDUALS YOU SUPERVI	SE:	
R	ISK MANAGEMENT				
IS T	HERE A FORMAL RISK MANAGEMENT PROGRAM?			☐ YE	s 🗌 no
IS T	HERE A FULL-TIME RISK MANAGER?				s 🗌 NO
IF	NO, WHAT ARE THEIR OTHER RESPONSIBILITIES AND	HOW MUCH TIME IS	S DEVOTED TO RISK MAI	_	<u> </u>
					•
WH	AT IS THE NAME AND TITLE OF THE PERSON RESP	PONSIBLE FOR RIS	K MANAGEMENT:		
NAM	E		TITLE		
INAIYI	L		IIILE		
IS T	HE RISK MANAGER RESPONSIBLE FOR REVIEWIN	NG INCIDENT REPO	RTS?	☐ YE	s 🗌 no
IS T	HERE A WRITTEN INCIDENT REPORTING PROCE	OURF?		□ve	S 🗌 NO
				_	_
	YES, DOES THIS PROCEDURE REQUIRE REVIEW AND A	APPROPRIATE CORRE	CIIVE ACTION BE TAKE		S NO
	FOLLOW-UP MADE TO ASSURE COMPLIANCE?			☐ YES	S NO
IS T	HERE AN ON-GOING QUALITY ASSURANCE (QA)	COMMITTEE IN PLA	ACE?	☐ YE	S 🗌 NO
	YES, IS THE PERSON RESPONSIBLE FOR RISK MANAG		THIS COMMITTEE?	☐ YES	5 □ NO
2. T	O WHOM IS THE QUALITY ASSURANCE COMMITTEE AC	COUNTABLE?			
N	AME		TITLE		
	"HAT QUALITY INDICATORS ARE MONITORED (PLEASE	LIST)?			
J	7771 Q071277 171313 170 170 7712 70112 70112 (1 22 132				
4 D	O YOU MONITOR INFECTION RATES AT YOUR FACILITI	FS?		□∨E	s 🗆 NO
	HERE AN ACTIVE PEER REVIEW PROCESS FOR PH	YSICIANS WHICH	IS PART OF THE QUAL		s 🗌 no
	IAGEMENT PROGRAM?				⊃ □ NO
IF	NO, PLEASE EXPLAIN:				
IS T	HERE AN ON-GOING CONTINUING EDUCATION P		NURSING STAFF?		ES NO
		(OTHER ALLIED HEALTH P	PROFESSIONALS? Y	ES NO
NAN	IE OF THE PERSON OUR RISK MANAGEMENT CON	SULTANT MAY CON	ITACT FOR AN ON-SIT	E VISIT:	
N	AME		TITLE		
C	REDENTIALING				
WH	EN HIRING PROFESSIONALS AND SUPPORT STAF	F DO YOU:			
1. V	ERIFY EDUCATIONAL BACKGROUND?			☐ YE	S 🗌 NO
	HECK ALL REFERENCES INCLUDING PAST EMPLOYERS?				s 🗆 NO
		TONG OF 575	ADV ACTIONS BY		
- ≺ C	HECK FOR PENDING LICENSE SUSPENSIONS, REVOCAT	IONS, OR DISCIPLINA	AKY ACITONS BY OTHER	FACILITIES? ∐YE	S □NO
J. C				□YE	s 🗌 no
	HECK CRIMINAL HISTORY?				
4. C	HECK CRIMINAL HISTORY? EQUIRE PRIOR MEDICAL PROFESSIONAL CLAIM HISTOF	RY?			s 🗌 no

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	IS AN ONGOING QUALITY ASSURAN					TIMICAL W	, N. T.	YES NO
	DO MEDICAL STAFF BYLAWS REQUI			ING AT Y	OUR FACILITY		Г	□YES □NO
	TO MAINTAIN PROFESSIONAL LIAB 1. IF YES, WHAT ARE THE MINIMUM			ED?	\$	/		
	ARE CERTIFICATES OF INSURANCE		-		·		· —	IS IN PLACE?
	WHAT ARE THE MINIMUM LIMITS O	OF LIABILITY THA	AT YOU REQ	UIRE NO		EDICAL PRO		YES □NO NALS WORKING
	AT YOUR FACILITY TO CARRY? ARE CERTIFICATES OF INSURANCE OF	ODTAINED AT LEAC	\$_ TANNUALLY	EDOM CA	/ \$	WEDIEV COV	EDACE 70	IN DI ACES
	HAS THE LICENSE OF ANY PHYSICI							YES NO
	SUSPENDED IN THE LAST FIVE YEA		ARE PROVI	DEK BEEN	RESTRICTED, R	EVOKED OK	[YES NO
	IF YES, PLEASE EXPLAIN:							
	HAVE YOU MADE REPORTS TO THE						-	
	SUSPENSION OR PROFESSIONAL LI	IABILITY PAYMEI	NT INVOLV	ING ANY	MEMBER OF THE	MEDICAL S	TAFF [YES NO
	DURING THE LAST FIVE YEARS?							
	IF YES, PLEASE EXPLAIN:							
	PHYSICAL PLANT							
	PLEASE FURNISH THE FOLLOWING YOU. A SEPARATE SUMMARY OF LO BELOW IS FURNISHED.							
	ADDRESS OF PROPERTY TO BE INSURED	USE/OCCUPANCY	SQUARE FOOTAGE	AGE	TYPE OF CONSTRUCTION	NUMBER OF STORIES	F	FIRE PROTECTION*
	PATIENT CARE BUILDINGS:		. CUIAGE		30.131.KGC110N	J. GRALO		
l						1		
ŀ	OTHER BUILDINGS:				-	-		
l								
L		THERE IS A	CDDINIZIES	CVCTERA	ELILI DADTIAL CO	NO CORTAIN	D CVCTT	M
	*FOR EACH BUILDING INDICATE IF 1	THERE IS A:			FULL, PARTIAL OR EAT DETECTOR	NO SPRINKLE	er syste	М
	*FOR EACH BUILDING INDICATE IF 1		SMOKE DET FIRE ALARM	ECTOR, HE I - CENTRA	EAT DETECTOR LL STATION OR LOG	CAL ALARM		М
		THE NATIONAL F	SMOKE DET FIRE ALARM	ECTOR, HE I - CENTRA	EAT DETECTOR LL STATION OR LOG	CAL ALARM	.	M ☐ YES ☐ NO
	*FOR EACH BUILDING INDICATE IF T	THE NATIONAL F	SMOKE DET FIRE ALARM	ECTOR, HE I - CENTRA	EAT DETECTOR LL STATION OR LOG	CAL ALARM	.	
	*FOR EACH BUILDING INDICATE IF TO ALL FACILITIES COMPLY WITH SAFETY CODE 2000 EDITION OR NE	THE NATIONAL F	SMOKE DET FIRE ALARM	ECTOR, HE I - CENTRA	EAT DETECTOR LL STATION OR LOG	CAL ALARM	.	
	*FOR EACH BUILDING INDICATE IF TO ALL FACILITIES COMPLY WITH SAFETY CODE 2000 EDITION OR NE IF NO, PLEASE EXPLAIN: GENERAL LIABILITY DO YOU DESIRE GENERAL LIABILIT	THE NATIONAL F EWER?	SMOKE DET FIRE ALARM IRE PROTE	ECTOR, HE I - CENTRA	EAT DETECTOR LL STATION OR LOG	CAL ALARM	[
	*FOR EACH BUILDING INDICATE IF TO ALL FACILITIES COMPLY WITH SAFETY CODE 2000 EDITION OR NE IF NO, PLEASE EXPLAIN: GENERAL LIABILITY DO YOU DESIRE GENERAL LIABILIT If yes, complete this section. If no,	THE NATIONAL F EWER? FY COVERAGE? skip to Section X	SMOKE DET FIRE ALARM IRE PROTE	ECTOR, HE	EAT DETECTOR IL STATION OR LOC SOCIATION (NFF	CAL ALARM P A) 101 LIF I	Ξ [□yes □no ——
	*FOR EACH BUILDING INDICATE IF TO THE SAFETY CODE 2000 EDITION OR NETED TO THE SAFETY ENDING THE SAFETY CODE 2000 EDITION OR NETED TO THE SAFETY ENDING THE	THE NATIONAL F EWER? TY COVERAGE? skip to Section X RECTIVE MAINTE	SMOKE DET FIRE ALARM IRE PROTE	ECTOR, HE	EAT DETECTOR IL STATION OR LOC SOCIATION (NFF	CAL ALARM P A) 101 LIF I	Ξ [□yes □no ——
	*FOR EACH BUILDING INDICATE IF TO ALL FACILITIES COMPLY WITH SAFETY CODE 2000 EDITION OR NE IF NO, PLEASE EXPLAIN: GENERAL LIABILITY DO YOU DESIRE GENERAL LIABILIT	THE NATIONAL F EWER? TY COVERAGE? skip to Section X RECTIVE MAINTE AT THE FACILITY	SMOKE DET FIRE ALARM IRE PROTE	ECTOR, HE I - CENTRA CTION AS DGRAM IN	EAT DETECTOR IL STATION OR LOO SOCIATION (NFF	CAL ALARM PA) 101 LIFE	≡ [[AL [YES NO
	*FOR EACH BUILDING INDICATE IF TO ALL FACILITIES COMPLY WITH SAFETY CODE 2000 EDITION OR NET IF NO, PLEASE EXPLAIN: GENERAL LIABILITY DO YOU DESIRE GENERAL LIABILITY If yes, complete this section. If no, IS THERE A PREVENTIVE AND CORESURGICAL MACHINES OR DEVICES 1. HOW OFTEN ARE NON-EXPENDABLE	THE NATIONAL F EWER? TY COVERAGE? skip to Section X RECTIVE MAINTE AT THE FACILITY MEDICAL OR SURG	SMOKE DET FIRE ALARM IRE PROTEG C. NANCE PRO 7? SICAL MACHI	ECTOR, HE I - CENTRA CTION AS OGRAM IN NES OR DE	EAT DETECTOR IL STATION OR LOG SOCIATION (NFF	CAL ALARM PA) 101 LIFE BIO-MEDIC	[[[[] [] [] [] [] [] [] [] [YES
	*FOR EACH BUILDING INDICATE IF TO ALL FACILITIES COMPLY WITH SAFETY CODE 2000 EDITION OR NET OF THE SAFETY CODE 2000 EDITION OR NET OF THE SAFETY CODE 2000 EDITION OR NET OF THE SAFETY COMPLETE OF THE SAFET	THE NATIONAL FEWER? TY COVERAGE? skip to Section X RECTIVE MAINTE AT THE FACILITY MEDICAL OR SURG	SMOKE DET FIRE ALARM IRE PROTEG C. NANCE PRO C? SICAL MACHI	ECTOR, HE - CENTRA CTION AS DGRAM IN NES OR DE	EAT DETECTOR IL STATION OR LOO SOCIATION (NFF	CAL ALARM PA) 101 LIFE BIO-MEDIC AND MAINTA DEPENDENT COL	E [AL [AINED? _	YES NO
	*FOR EACH BUILDING INDICATE IF TO ALL FACILITIES COMPLY WITH SAFETY CODE 2000 EDITION OR NET IF NO, PLEASE EXPLAIN: GENERAL LIABILITY DO YOU DESIRE GENERAL LIABILITY If yes, complete this section. If no, IS THERE A PREVENTIVE AND CORESURGICAL MACHINES OR DEVICES 1. HOW OFTEN ARE NON-EXPENDABLE	THE NATIONAL FEWER? TY COVERAGE? skip to Section X RECTIVE MAINTE AT THE FACILITY MEDICAL OR SURG	SMOKE DET FIRE ALARM IRE PROTEG C. NANCE PRO C? SICAL MACHI	ECTOR, HE - CENTRA CTION AS DGRAM IN NES OR DE	EAT DETECTOR IL STATION OR LOO SOCIATION (NFF PLACE FOR THE EVICES INSPECTED EMPLOYEES IN LIMIT THAT YOU F	CAL ALARM PA) 101 LIFE BIO-MEDIC AND MAINTA DEPENDENT COR REQUIRE THE	E [AL [AINED? _ NITRACTORS M TO CAF	YES NO
	*FOR EACH BUILDING INDICATE IF TO ALL FACILITIES COMPLY WITH SAFETY CODE 2000 EDITION OR NET OF THE SAFETY CODE 2000 EDITION OR NET OF THE SAFETY CODE 2000 EDITION OR NET OF THE SAFETY COMPLETE OF THE SAFET	THE NATIONAL FEWER? TY COVERAGE? skip to Section X RECTIVE MAINTE AT THE FACILITY MEDICAL OR SURGE ON THE ABOVE EC	SMOKE DET FIRE ALARM IRE PROTEG C. NANCE PRO 7? GICAL MACHI QUIPMENT? M GENERAL	ECTOR, HE - CENTRA CTION AS OGRAM IN NES OR DE	EAT DETECTOR IL STATION OR LOO SOCIATION (NFF PLACE FOR THE EVICES INSPECTED EMPLOYEES IN LIMIT THAT YOU F	CAL ALARM PA) 101 LIFE BIO-MEDIC AND MAINTA DEPENDENT COR REQUIRE THE /	[AL [AINED? _ NITRACTORS M TO CAF	YES NO
	*FOR EACH BUILDING INDICATE IF TO ALL FACILITIES COMPLY WITH SAFETY CODE 2000 EDITION OR NE IF NO, PLEASE EXPLAIN: GENERAL LIABILITY DO YOU DESIRE GENERAL LIABILITY If yes, complete this section. If no, IS THERE A PREVENTIVE AND CORE SURGICAL MACHINES OR DEVICES 1. HOW OFTEN ARE NON-EXPENDABLE 2. WHO PERFORMS THE MAINTENANCE 3. IF INDEPENDENT CONTRACTOR, WH	THE NATIONAL F EWER? TY COVERAGE? skip to Section X RECTIVE MAINTE AT THE FACILITY MEDICAL OR SURG ON THE ABOVE EC AT IS THE MINIMU INSURANCE ANNUA	SMOKE DET FIRE ALARM IRE PROTECT. C. NANCE PROTECT. GICAL MACHI QUIPMENT? M GENERAL ALLY TO VER	ECTOR, HE - CENTRA CTION AS DGRAM IN NES OR DE LIABILITY IFY THIS C	EAT DETECTOR IL STATION OR LOX SOCIATION (NFF I PLACE FOR THE EVICES INSPECTED EMPLOYEES IN LIMIT THAT YOU F \$ COVERAGE IS IN PL	BIO-MEDIC AND MAINTA DEPENDENT COI REQUIRE THE / _ACE?	E [AL [AINED? _ NITRACTORS M TO CAF \$	YES
	*FOR EACH BUILDING INDICATE IF TO ALL FACILITIES COMPLY WITH SAFETY CODE 2000 EDITION OR NEIF NO, PLEASE EXPLAIN: GENERAL LIABILITY DO YOU DESIRE GENERAL LIABILITY To yes, complete this section. If no, is there a preventive and core surgical machines or devices 1. HOW OFTEN ARE NON-EXPENDABLE 2. WHO PERFORMS THE MAINTENANCE 3. IF INDEPENDENT CONTRACTOR, WH 4. DO YOU OBTAIN A CERTIFICATE OF	THE NATIONAL F EWER? TY COVERAGE? skip to Section X RECTIVE MAINTE AT THE FACILITY MEDICAL OR SURG ON THE ABOVE EC AT IS THE MINIMU INSURANCE ANNUA PMENT USED AT	SMOKE DET FIRE ALARM IRE PROTECT. C. NANCE PROTECT. GICAL MACHI QUIPMENT? M GENERAL ALLY TO VER YOUR FACI	ECTOR, HE - CENTRA CTION AS DGRAM IN NES OR DE LIABILITY LITY THIS C	EAT DETECTOR L STATION OR LOT SOCIATION (NFF PLACE FOR THE EVICES INSPECTED EMPLOYEES IN LIMIT THAT YOU F COVERAGE IS IN PL NED BY PHYSICIA	BIO-MEDIC AND MAINTA DEPENDENT COI REQUIRE THE ACE?	E [AL [AINED? _ NITRACTORS M TO CAF \$ [YES NO YES NO YES NO RRY?
	*FOR EACH BUILDING INDICATE IF TO ALL FACILITIES COMPLY WITH SAFETY CODE 2000 EDITION OR NEIF NO, PLEASE EXPLAIN: GENERAL LIABILITY DO YOU DESIRE GENERAL LIABILITY If yes, complete this section. If no, IS THERE A PREVENTIVE AND CORESURGICAL MACHINES OR DEVICES 1. HOW OFTEN ARE NON-EXPENDABLE 2. WHO PERFORMS THE MAINTENANCE 3. IF INDEPENDENT CONTRACTOR, WH 4. DO YOU OBTAIN A CERTIFICATE OF	THE NATIONAL F EWER? TY COVERAGE? skip to Section X RECTIVE MAINTE AT THE FACILITY MEDICAL OR SURG ON THE ABOVE EC AT IS THE MINIMU INSURANCE ANNUA PMENT USED AT	SMOKE DET FIRE ALARM IRE PROTECT. C. NANCE PROTECT. GICAL MACHI QUIPMENT? M GENERAL ALLY TO VER YOUR FACI	ECTOR, HE - CENTRA CTION AS DGRAM IN NES OR DE LIABILITY LITY THIS C	EAT DETECTOR L STATION OR LOT SOCIATION (NFF PLACE FOR THE EVICES INSPECTED EMPLOYEES IN LIMIT THAT YOU F COVERAGE IS IN PL NED BY PHYSICIA	BIO-MEDIC AND MAINTA DEPENDENT COI REQUIRE THE ACE?	E [AL [AINED? _ NITRACTORS M TO CAF \$ [YES
	*FOR EACH BUILDING INDICATE IF TO ALL FACILITIES COMPLY WITH SAFETY CODE 2000 EDITION OR NEIF NO, PLEASE EXPLAIN: GENERAL LIABILITY DO YOU DESIRE GENERAL LIABILITY AND CORRESSION OF THE AID CORE SURGICAL MACHINES OR DEVICES 1. HOW OFTEN ARE NON-EXPENDABLE 2. WHO PERFORMS THE MAINTENANCE 3. IF INDEPENDENT CONTRACTOR, WH 4. DO YOU OBTAIN A CERTIFICATE OF IS ANY OF THE BIO-MEDICAL EQUI IF YES, WHO IS RESPONSIBLE FOR THE BIO YOUR BION OF THE B	THE NATIONAL F EWER? TY COVERAGE? Skip to Section X RECTIVE MAINTER AT THE FACILITY MEDICAL OR SURGE ON THE ABOVE EC AT IS THE MINIMU INSURANCE ANNUX PMENT USED AT THE PREVENTIVE M	SMOKE DET FIRE ALARM IRE PROTECT. C. NANCE PROTECT. GICAL MACHI QUIPMENT? M GENERAL ALLY TO VER YOUR FACI AINTENANCE	ECTOR, HE - CENTRA CTION AS DGRAM IN NES OR DE LIABILITY LIFY THIS (LITY OWN E, INSPECT	EAT DETECTOR IL STATION OR LOC SOCIATION (NFF I PLACE FOR THE EVICES INSPECTED EMPLOYEES IN LIMIT THAT YOU F \$ COVERAGE IS IN PL NED BY PHYSICIA TION AND REPAIR (BIO-MEDIC AND MAINTA DEPENDENT COI REQUIRE THE ACE? ANS?	E [AL [AINED? _ NITRACTORS M TO CAF \$ _ [PMENT?	YES
	*FOR EACH BUILDING INDICATE IF TO ALL FACILITIES COMPLY WITH SAFETY CODE 2000 EDITION OR NEIF NO, PLEASE EXPLAIN: GENERAL LIABILITY DO YOU DESIRE GENERAL LIABILITY If yes, complete this section. If no, IS THERE A PREVENTIVE AND CORESURGICAL MACHINES OR DEVICES 1. HOW OFTEN ARE NON-EXPENDABLE 2. WHO PERFORMS THE MAINTENANCE 3. IF INDEPENDENT CONTRACTOR, WH 4. DO YOU OBTAIN A CERTIFICATE OF	THE NATIONAL F EWER? TY COVERAGE? Skip to Section X RECTIVE MAINTER AT THE FACILITY MEDICAL OR SURGE ON THE ABOVE EC AT IS THE MINIMU INSURANCE ANNUX PMENT USED AT THE PREVENTIVE M	SMOKE DET FIRE ALARM IRE PROTECT. C. NANCE PROTECT. GICAL MACHI QUIPMENT? M GENERAL ALLY TO VER YOUR FACI AINTENANCE	ECTOR, HE - CENTRA CTION AS DGRAM IN NES OR DE LIABILITY LIFY THIS (LITY OWN E, INSPECT	EAT DETECTOR IL STATION OR LOC SOCIATION (NFF I PLACE FOR THE EVICES INSPECTED EMPLOYEES IN LIMIT THAT YOU F \$ COVERAGE IS IN PL NED BY PHYSICIA TION AND REPAIR (BIO-MEDIC AND MAINTA DEPENDENT COI REQUIRE THE ACE? ANS?	E [AL [AINED? _ NITRACTORS M TO CAF \$ _ [PMENT?	YES NO YES NO YES NO RRY? YES NO
	*FOR EACH BUILDING INDICATE IF TO ALL FACILITIES COMPLY WITH SAFETY CODE 2000 EDITION OR NEIF NO, PLEASE EXPLAIN: GENERAL LIABILITY DO YOU DESIRE GENERAL LIABILITY DO YOU DESIRE GENERAL LIABILITY If yes, complete this section. If no, is there a preventive and coresurgical machines or devices 1. HOW OFTEN ARE NON-EXPENDABLE 2. WHO PERFORMS THE MAINTENANCE 3. IF INDEPENDENT CONTRACTOR, WH 4. DO YOU OBTAIN A CERTIFICATE OF IS ANY OF THE BIO-MEDICAL EQUITE IF YES, WHO IS RESPONSIBLE FOR TO DO YOU LEND OR DONATE YOUR BI	THE NATIONAL F EWER? TY COVERAGE? Skip to Section X RECTIVE MAINTER AT THE FACILITY MEDICAL OR SURGE ON THE ABOVE EC AT IS THE MINIMU INSURANCE ANNUX PMENT USED AT THE PREVENTIVE M	SMOKE DET FIRE ALARM IRE PROTECT. C. NANCE PROTECT. GICAL MACHI QUIPMENT? M GENERAL ALLY TO VER YOUR FACI AINTENANCE	ECTOR, HE - CENTRA CTION AS DGRAM IN NES OR DE LIABILITY LIFY THIS (LITY OWN E, INSPECT	EAT DETECTOR IL STATION OR LOC SOCIATION (NFF I PLACE FOR THE EVICES INSPECTED EMPLOYEES IN LIMIT THAT YOU F \$ COVERAGE IS IN PL NED BY PHYSICIA TION AND REPAIR (BIO-MEDIC AND MAINTA DEPENDENT COI REQUIRE THE ACE? ANS?	E [AL [AINED? _ NITRACTORS M TO CAF \$ _ [PMENT?	YES NO YES NO YES NO RRY? YES NO
	*FOR EACH BUILDING INDICATE IF TO ALL FACILITIES COMPLY WITH SAFETY CODE 2000 EDITION OR NEIF NO, PLEASE EXPLAIN: GENERAL LIABILITY DO YOU DESIRE GENERAL LIABILITY DO YOU DESIRE GENERAL LIABILITY If yes, complete this section. If no, is there a preventive and coresurgical machines or devices 1. HOW OFTEN ARE NON-EXPENDABLE 2. WHO PERFORMS THE MAINTENANCE 3. IF INDEPENDENT CONTRACTOR, WH 4. DO YOU OBTAIN A CERTIFICATE OF IS ANY OF THE BIO-MEDICAL EQUITE IF YES, WHO IS RESPONSIBLE FOR TO DO YOU LEND OR DONATE YOUR BI	THE NATIONAL FEWER? TY COVERAGE? skip to Section X RECTIVE MAINTER AT THE FACILITY MEDICAL OR SURGE ON THE ABOVE ECO AT IS THE MINIMU INSURANCE ANNUA PMENT USED AT THE PREVENTIVE M IO-MEDICAL EQU	SMOKE DET FIRE ALLARM IRE PROTECT. (. NANCE PROTECT. () SICAL MACHI QUIPMENT? IM GENERAL ALLY TO VER YOUR FACI IAINTENANCE IPMENT TO	ECTOR, HE I - CENTRA CTION AS DEFINITION AS DEFIN	EAT DETECTOR IL STATION OR LOC SOCIATION (NFF I PLACE FOR THE EVICES INSPECTED EMPLOYEES IN LIMIT THAT YOU F \$ COVERAGE IS IN PL NED BY PHYSICIA TION AND REPAIR (BIO-MEDIC AND MAINTA DEPENDENT COI REQUIRE THE ACE? ANS?	E [AL [AINED? _ NITRACTORS M TO CAF \$	YES NO YES NO YES NO RRY? YES NO YES NO
	*FOR EACH BUILDING INDICATE IF TO ALL FACILITIES COMPLY WITH SAFETY CODE 2000 EDITION OR NEIF NO, PLEASE EXPLAIN: GENERAL LIABILITY DO YOU DESIRE GENERAL LIABILITY If yes, complete this section. If no, is there a preventive and corr surgical machines or devices 1. HOW OFTEN ARE NON-EXPENDABLE 2. WHO PERFORMS THE MAINTENANCE 3. IF INDEPENDENT CONTRACTOR, WH 4. DO YOU OBTAIN A CERTIFICATE OF IS ANY OF THE BIO-MEDICAL EQUITY IF YES, WHO IS RESPONSIBLE FOR TO YOU LEND OR DONATE YOUR BITY IF YES, DESCRIBE:	THE NATIONAL FEWER? TY COVERAGE? skip to Section X RECTIVE MAINTER AT THE FACILITY MEDICAL OR SURGE ON THE ABOVE ECO AT IS THE MINIMU INSURANCE ANNUA PMENT USED AT THE PREVENTIVE M IO-MEDICAL EQUIPMENT FROM	SMOKE DET FIRE ALLARM IRE PROTECT. (. NANCE PROTECT. () SICAL MACHI QUIPMENT? M GENERAL ALLY TO VER YOUR FACI IAINTENANCE IPMENT TO	ECTOR, HE I - CENTRA CTION AS DEFINITION AS DEFIN	EAT DETECTOR IL STATION OR LOC SOCIATION (NFF I PLACE FOR THE EVICES INSPECTED EMPLOYEES IN LIMIT THAT YOU F \$ COVERAGE IS IN PL NED BY PHYSICIA TION AND REPAIR (BIO-MEDIC AND MAINTA DEPENDENT COI REQUIRE THE ACE? ANS?	E [AL [AINED? _ NITRACTORS M TO CAF \$	YES NO YES NO YES NO RRY? YES NO

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	GENERAL LIABILITY (CONTINUED)	
Ξ.	DO YOU USE AN ADVERTISING AGENCY?	☐YES ☐ NO
	1. IF YES, WHAT IS THE MINIMUM PROFESSIONAL LIABILITY LIMIT THAT YOU REQUIRE THEM TO CARRY?	
	\$	
	2. ARE YOU INCLUDED AS AN ADDITIONAL INSURED ON THE ADVERTISING AGENCY'S POLICY?	YES NO
	3. IS THERE A HOLD HARMLESS AGREEMENT IN THE CONTRACT IN FAVOR OF YOUR FACILITY?	YES NO
	ARE THERE ANY PLANS FOR NEW CONSTRUCTION OR RENOVATIONS DURING THE NEXT 12 MONTHS?	☐YES ☐ NO
	IF YES, PLEASE DESCRIBE THE CHANGES PLANNED INCLUDING THE TIME FRAME AND THE ESTIMATED COST:	
	PLEASE INDICATE BELOW WHICH OF THE FOLLOWING APPLY AND SPECIFY THE CORRESPONDING PROJ AMOUNT OF RECEIPTS FOR THE NEXT 12 MONTHS:	ECTED NUMBER OR
	HABITATIONAL RISK: INDICATE IF AN: APARTMENT DWELLING HOTEL	
	a. ARE THERE AT LEAST TWO EXITS LOCATED REMOTELY FROM EACH OTHER?	YES NO
	 b. FOR APARTMENT BUILDINGS AND HOTELS, ARE THERE LIGHTED EMERGENCY EXIT SIGNS? □ PAY PARKING RECEIPTS PER YEAR: 	YES NO
	☐ SPECIAL ATHLETIC OR FUND RAISING EVENTS RECEIPTS PER YEAR:	
	2. DESCRIBE PLANNED EVENTS FOR THE UPCOMING YEAR AND INDICATE IF ALCOHOL WILL BE SERVED:	
		
١.	DO YOU LEASE OR RENT SPACE TO OTHERS?	YES NO
	IF YES, INDICATE THE FOLLOWING:	
	CITY, STATE, AND ZIP CODE	
	SQUARE FOOTAGE OCCUPANCY/USE OF SPACE	_
	 DOES YOUR LEASE REQUIRE THE TENANT TO CARRY GENERAL LIABILITY INSURANCE WITH AT LEAST A \$1,000,000 LIMIT? 	YES NO
	2. DO YOU OBTAIN A CERTIFICATE OF INSURANCE ANNUALLY TO VERIFY THIS COVERAGE IS IN PLACE?	YES NO
	3. IS THE TENANT REQUIRED TO LIST YOU AS AN ADDITIONAL INSURED ON THEIR GENERAL LIABILITY POLICY?	YES NO
Ī	EXCESS LIABILITY	
	DO YOU DESIRE EXCESS LIABILITY COVERAGE? If yes, complete this section. If no, skip to Section XI.	☐YES ☐NO
	HAVE YOUR EXCESS PROFESSIONAL OR COMMERCIAL GENERAL LIABILITY LIMITS BEEN INCREASED WITHIN THE LAST FIVE YEARS?	YES NO
	IF YES, WHAT WAS THE PRIOR LIMIT AND WHEN WAS IT INCREASED?	
•	COVERAGE HISTORY AND INFORMATION	
	** NOTE: QUESTION XI. A. IS NOT TO BE COMPLETED IN THE STATE OF MISSOURI.	
	HAS ANY COMPANY EVER CANCELLED OR REFUSED TO OFFER INSURANCE COVERAGE?	П П
	IF YES, PLEASE PROVIDE DETAILS:	☐YES ☐ NO
	II 160/166701 PROVIDE DETAILS.	
	PLEASE CHECK WHICH TYPE OF NOTICE YOUR PRESENT PROFESSIONAL LIABILITY INSURER REQUIRES FORMALLY RECOGNIZE A CLAIM UNDER THEIR POLICY:	BEFORE THEY WIL
	SUMMONS AND COMPLAINT OR ATTORNEY DEMAND LETTER.	
	☐ WRITTEN NOTICE FROM YOU THAT A POTENTIALLY COMPENSABLE EVENT HAS OCCURRED.	
	HAVE YOU CONDUCTED A RECENT REVIEW OF ALL KNOWN CLAIMS AS WELL AS ANY INCIDENTS WHICH	☐YES ☐ NO
	MAY GIVE RISE TO FUTURE CLAIMS AND HAVE YOU FORWARDED THEM TO YOUR CURRENT INSURER?	
•		EW:
	MAY GIVE RISE TO FUTURE CLAIMS AND HAVE YOU FORWARDED THEM TO YOUR CURRENT INSURER?	EW:

XI. COVERAGE HISTORY AND INFORMATION (CONTINUED) D. PLEASE PROVIDE YOUR INSURANCE HISTORY FOR THE LAST FIVE YEARS: MOST RECENT **POLICY PERIOD** YEAR 1 PRIOR **YEAR 2 PRIOR YEAR 3 PRIOR YEAR 4 PRIOR** YEAR PROFESSIONAL LIABILITY INSURANCE COMPANY CLAIMS-MADE (CM) OR OCCURRENCE (O) PREMILIN **GENERAL LIABILITY** INSURANCE COMPANY LIMITS CLAIMS-MADE (CM) OR OCCURRENCE (O) **EXCESS LIABILITY** INSURANCE COMPANY LIMITS CLAIMS-MADE (CM) OR OCCURRENCE (O) PREMIUN XII. LOSS INFORMATION (IMPORTANT! COMPLETE FULLY) For EACH claim, potential claim or suit mentioned below, please complete Section I (Loss History) of the Imaging Center Supplemental Application. A. Has your organization (independently or through a named insured) been involved now or in the past, directly or indirectly, in a claim, potential claim, or suit arising out of the rendering or failing to render professional services involving former or present partners, members of the corporation, or any former or present employee or independent contractor of the corporation, partnership or organization? ☐YES ☐ NO If yes, how many? If yes, have these been reported to your insurer? ☐YES ☐ NO B. Does your organization or any of your employees/contractors have knowledge of any incident, or unexpected adverse outcome resulting in injury or death, claim, potential claim, or suit in which you may become involved, including without limitation, knowledge of any injury arising out of the rendering or failing to render professional services which may give rise to a claim involving former or present partners, members of the corporation, or any former or present employee or independent contractor of the corporation, partnership or organization which may give rise to a claim? □YES □NO If yes, how many? ☐YES ☐NO If yes, have these been reported to your insurer? XIII. ATTACHMENTS A COPY OF THE FOLLOWING INFORMATION MUST BE SUBMITTED WITH THIS APPLICATION: A. A COPY OF YOUR CERTIFICATE / ACCREDITATION INCLUDING ANY RECOMMENDATIONS MADE. B. FINANCIAL INFORMATION. THE MOST RECENT THREE (3) YEARS OF FINANCIAL STATEMENTS INCLUDING THE AUDITOR'S OPINION, IF APPLICABLE. C. MEDICAL STAFF BYLAWS AND RULES AND REGULATIONS. D. COPY OF YOUR LETTERHEAD. E. LIST OF OPERATIONS OR ACTIVITIES PERFORMED THAT ARE NOT OTHERWISE DESCRIBED IN THE APPLICATION. LOSS INFORMATION. RECENTLY VALUED LOSS RUNS FROM INSURANCE CARRIERS COVERING THE LAST TEN (10) FULL YEARS. THE LOSS INFORMATION SHOULD INCLUDE PAID AND RESERVED AMOUNTS. G. ANNUAL REPORT (IF ONE IS PUBLISHED). H. ALL CURRENT ADVERTISING MATERIALS. ORGANIZATIONAL CHART INCLUDING THE NAMES OF ALL ENTITIES AND A BRIEF DESCRIPTION OF OPERATIONS.

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COPY OF YOUR CURRENT INSURANCE POLICY.

IMPORTANT NOTICE - REPRESENTATIONS, AUTHORIZATIONS, RELEASE AND NOTICES **IMPORTANT NOTICE:** THIS INSURANCE MAY CONTAIN CLAIMS MADE COVERAGE. CERTAIN COVERAGES OF THIS INSURANCE MAY BE LIMITED TO LIABILITY FOR INJURIES FOR WHICH CLAIMS ARE FIRST MADE DURING THE POLICY PERIOD ARISING OUT OF INCIDENTS OR ACTS THAT FIRST OCCURRED ON OR AFTER THE APPLICABLE RETROACTIVE DATE. PLEASE READ AND REVIEW THE POLICY CAREFULLY. FRAUD NOTICE: 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 SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES, WHICH MAY INCLUDE VOIDING OF THE POLICY IF ALLOWED BY STATE LAW. INITIAL HERE MANDATORY: ALL NEW JERSEY APPLICANTS MUST READ AND INITIAL THE FOLLOWING: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES. INITIAL HERE PLEASE READ AND SIGN ON BEHALF OF THE ENTITY APPLYING FOR COVERAGE HEREIN: I HEREBY DECLARE THAT THE ABOVE STATEMENTS AND PARTICULARS ARE TRUE AND THAT NO MATERIAL FACT HAS BEEN KNOWINGLY SUPPRESSED OR MISSTATED. I AGREE THAT THIS APPLICATION SHALL BE THE BASIS OF THE CONTRACT WITH THE COMPANY. I AGREE TO NOTIFY THE COMPANY IF THERE IS ANY FUTURE MATERIAL CHANGE IN ANY ANSWER TO THIS APPLICATION, INCLUDING WITHOUT LIMITATION, ANY CHANGE IN PROFESSIONAL SPECIALTY, AFFILIATION, OR WORKING ARRANGEMENT WITH ANY PHYSICIAN, DENTIST, FIRM, OR PROFESSIONAL ASSOCIATION. I UNDERSTAND THAT ANY MATERIAL MISREPRESENTATION OR OMISSION MADE ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT EFFECT OR PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND COVERAGE. BY MAKING THIS APPLICATION, I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATION THAT COVERAGE HAS OR WILL BE EXTENDED OR THAT A POLICY OF INSURANCE WILL BE ISSUED. I FURTHER UNDERSTAND AND AGREE THAT THERE IS NO RIGHT TO DEMAND OR EXPECT COVERAGE UNTIL THE COMPANY HAS: (1) RECEIVED A COMPLETED APPLICATION; (2) OFFERED 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 THE PREMIUM OR FIRST INSTALLMENT IS PAID 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 THESE TERMS ARE NOT COMPLIED WITH, THERE WILL BE 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 INDIVIDUALS OR ENTITIES TO VERIFY AND/OR ASCERTAIN INFORMATION REGARDING 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 REQUESTED, WHICH THE COMPANY, IN GOOD FAITH, BELIEVES TO BE APPLICABLE AND PERTINENT TO THIS APPLICATION AND IF ISSUED, THE CONTRACT OF INSURANCE ISSUED HEREUNDER.

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DATE

TITLE

SIGNATURE OF AUTHORIZED INDIVIDUAL

THE MEDICAL PROTECTIVE COMPANY

IMAGING CENTER SUPPLEMENTAL APPLICATION

I. LOSS HISTORY

IF YOU HAVE BEEN INSURED WITH THE MEDICAL PROTECTIVE COMPANY OR NATIONAL FIRE AND MARINE FOR LESS THAN TEN YEARS OR IF YOUR FACILITY PARTICIPATED IN A SELF-INSURED RETENTION ARRANGEMENT, PROVIDE A RECENTLY VALUED CLAIMS EXHIBIT FOR ALL CLAIMS DURING THE LAST TEN FULL YEARS. ONLY PROVIDE THE CLAIMS INFORMATION ON THOSE CLAIMS WHICH ARE NOT BEING HANDLED DIRECTLY BY THE MEDICAL PROTECTIVE COMPANY OR NATIONAL FIRE & MARINE INSURANCE COMPANY.

F MAKING ADDITIONAL COPIES, PLEASE ENTER APPLICANT'S NAME HERE:		
NOTE: ADDITIONAL DOCUMENTATION (OFFICE/HOSPITAL RECORDS) MAY BE REQUESTED AT THE UNDER DEPARTMENT'S DISCRETION. CLAIM NUMBER	₹WRITING	5
. CLAIMANT NAME:		AGE:
B. DATE OF TREATMENT AND/OR SURGERY, WHICH LED TO THE ALLEGATIONS AGAINST YOU.	MM	
C. DATE CLAIM/INCIDENT NOTICE RECEIVED. MM YYYY		
D. NAME OF DOCTOR(S), HEALTH CARE PROVIDER(S) OR OTHER HOSPITAL(S) IF ANY, INVOLV E. DEFENDING INSURANCE CARRIER NAME:	ED IN TH	IE CLAIM OR S
. WAS A CLAIM MADE OR A SUIT FILED?		☐ YES ☐ NO
E. DISPOSITION OR CURRENT STATUS OF CLAIM OR SUIT:		OPEN CLOSE
IF CLOSED, DATE OF CLOSING /SETTLEMENT OR AWARD:	-	<u>мм </u>
IF CLOSED, WAS PAYMENT MADE?	·	□YES □NO
IF NO, WAS CLAIM OR SUIT WITHDRAWN?		YES NO
AMOUNT PAID ON YOUR BEHALF:	\$	
TOTAL AMOUNT OF SETTLEMENT OR AWARD:	\$	
WAS THIS MATTER CLOSED WITH YOUR CONSENT?		YES NO
IF OPEN, HAS SETTLEMENT BEEN OFFERED?		YES NO
IF OPEN, HAS TRIAL DATE BEEN SET?		YES N
TRIAL DATE:	_	
I. NATURE OF ALLEGATIONS IN THE CLAIM OR SUIT: CONDITION TREATED:	ı	MM YYY
TREATMENT PROVIDED:		
ALLEGED NEGLIGENCE:		
ALLEGED INJURY:		
. PLEASE PROVIDE A NARRATIVE DESCRIPTION OF THE MEDICAL FACTS: (MUST INCLUDE, BU	T NOT L	MITED TO TH
TYPE OF TREATMENT AND/OR SURGERY INCLUDING YOUR LEVEL OF INVOLVEMENT).		

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II. SCHEDULE OF RELATED ENTITIES LIST OF ENTITIES RELATED TO THE NAMED INSURED (SUBSIDIARIES, JOINT VENTURES, LLCs, PARTNERSHIPS, ETC.) COVERAGE **INDICATE YOUR** DATE ACQUIRED, **DESIRED?** If yes, **OWNERSHIP** NAME OF ENTITY **DESCRIPTION OF OPERATIONS** CREATED OR indicate shared **PERCENTAGE IN MERGED** or separate THIS ENTITY limits. III. COVERAGES, LIMITS AND DEDUCTIBLES SCHEDULE (IF SHARED OR SEPARATE PHYSICIAN OR ALLIED **COVERAGE IS BEING REQUESTED)** PLEASE INDICATE THE COVERAGES, LIMITS AND DEDUCTIBLES DESIRED ON THE CHART BELOW COVERAGE REQUESTED LIMITS OCCURRENCE / CLAIMS-MADE **DEDUCTIBLE / SIR** IF THIS COVERAGE IS DESIRED. THE COVERAGE TYPE THE DEDUCTIBLE MUST BE THE PLEASE COMPLETE A SCHEDULE OF **PROFESSIONAL LIABILITY -**(OCCURRENCE/CLAIMS-MADE) SAME AS INDICATED IN THE MEDICAL PROFESSIONALS OR PROVIDE A MUST BE THE SAME AS INDICATED MAGING CENTER LIABILITY **EMPLOYED OR** IN THE IMAGING CENTER LIABILITY CONTRACTED PHYSICIANS, ROSTER WITH APPLICATION. EOUIVALENT INFORMATION. SUBMIT SURGEONS, RESIDENTS, APPLICATION. SEPARATE APPLICATIONS FOR EACH INTERNS, FELLOWS, INDIVIDUAL COVERAGE DESIRED. **DENTISTS AND ORAL** SURGEONS - SHARED IF THIS COVERAGE IS PROVIDED. THE FACILITY'S PROFESSIONAL LIABILITY LIMIT LIMIT COVERAGE WILL BE SHARED. IF THIS COVERAGE IS DESIRED. THE COVERAGE TYPE THE DEDUCTIBLE MUST BE THE **PROFESSIONAL LIABILITY -**PLEASE COMPLETE A SCHEDULE (OCCURRENCE/CLAIMS-MADE) SAME AS INDICATED IN THE EMPLOYED OR MUST BE THE SAME AS INDICATED IMAGING CENTER LIABILITY OF MEDICAL PROFESSIONALS CONTRACTED CRNAs. OR PROVIDE A ROSTER WITH IN THE IMAGING CENTER LIABILITY APPLICATION. NURSE MIDWIVES, CRNPs, EQUIVALENT INFORMATION. APPLICATION. PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS -IF THIS COVERAGE IS PROVIDED. THE SHARED LIMIT COVERAGE FACILITY'S PROFESSIONAL LIABILITY LIMIT WILL BE SHARED. IF THIS COVERAGE IS DESIRED. □ NONE □ \$5,000 □ \$10,000 OCCURRENCE PROFESSIONAL LIABILITY -PLEASE COMPLETE A SCHEDULE \$25,000 \$50,000 OF MEDICAL PROFESSIONALS CLAIMS MADE **EMPLOYED OR** OTHER \$ CONTRACTED PHYSICIANS, OR PROVIDE A ROSTER WITH RETRO DATE: _ SURGEONS, RESIDENTS, EQUIVALENT INFORMATION. INTERNS, FELLOWS, **DENTISTS AND ORAL** THE DEDUCTIBLE APPLIES TO: SLIBMIT SEPARATE APPLICATIONS SURGEONS - SEPARATE NOTE: THE UNDERWRITING FOR EACH INDIVIDUAL COVERAGE ☐ INDEMNITY ONLY LIMIT COVERAGE DEPARTMENT MAY REQUIRE THE DESTRED. ☐ INDEMNITY AND EXPENSE SEPARATE LIMIT COVERAGE BE THE SAME POLICY TYPE AS THE IMAGING CENTER. IF THIS COVERAGE IS DESIRED, **PROFESSIONAL LIABILITY -**☐ OCCURRENCE PLEASE COMPLETE A SCHEDULE □ NONE □ \$5,000 □ \$10,000 **EMPLOYED OR** OF MEDICAL PROFESSIONALS CLATMS MADE \$25,000 \$50,000 CONTRACTED CRNAs, OR PROVIDE A ROSTER WITH NURSE MIDWIVES, CRNPs, RETRO DATE: OTHER \$ EQUIVALENT INFORMATION. PODIATRISTS, PHYSICIAN ASSISTANTS AND NOTE: THE UNDERWRITING THE DEDUCTIBLE APPLIES TO: SUBMIT SEPARATE APPLICATIONS SURGICAL ASSISTANTS -DEPARTMENT MAY REQUIRE THE FOR EACH INDIVIDUAL COVERAGE ☐ INDEMNITY ONLY SEPARATE LIMIT SEPARATE LIMIT COVERAGE BE THE ☐ INDEMNITY AND EXPENSE COVERAGE. SAME POLICY TYPE AS THE IMAGING CENTER. **IMPORTANT NOTE:** UNLESS OTHERWISE INDICATED BELOW, REQUESTED COVERAGE WILL BE LIMITED TO PROFESSIONAL SERVICES RENDERED, OR WHICH SHOULD HAVE BEEN RENDERED, WHILE EMPLOYED OR UNDER CONTRACT WITH THE APPLICANT OR RELATED ENTITY (SERVICES LIMITED TO DUTY AND SCOPE OF SERVICES). CHECK ONE: ☐ LIMITED TO DUTY AND SCOPE OF APPLICANT AS INDICATED ABOVE

☐ REQUESTING 24-HOUR COVERAGE

IV. SCHEDULE OF MEDICAL PROFESSIONALS - PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND ORAL SURGEONS

IF SHARED LIMIT OR SEPARATE LIMIT COVERAGE IS BEING REQUESTED FOR PHYSICIANS, SURGEONS, RESIDENTS, INTERNS, FELLOWS, DENTISTS AND / OR ORAL SURGEONS, PLEASE PROVIDE THE INFORMATION BELOW. ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL THAT COVERAGE IS REQUESTED (SHARED LIMIT OR SEPARATE LIMIT COVERAGE). CLASSIFICATION AND RATING WILL BE BASED ON INFORMATION PROVIDED ON THE APPLICATION.

IF AN APPLICATION IS COMPLETED FOR AN INDIVIDUAL THAT CONFLICTS WITH THE INFORMATION BELOW, THE PROVIDER WILL BE SUBJECT TO RE-CLASSIFICATION AND RE-RATING BASED ON THE ACTIVITIES AND INFORMATION CONTAINED IN THE INDIVIDUAL APPLICATION.

NAME OF MEDICAL PROFESSIONAL	EMPLOYMENT STATUS: (C)ONTRACT (E)MPLOYED (F)ACULTY (R)ESIDENT	NUMBER OF PROCEDURES PERFORMED AT THE IMAGING CENTER	INDICATE: PHYSICIAN, SURGEON, RESIDENT, INTERN, FELLOW, DENTIST OR ORAL SURGEON	DATE OF EMPLOYMENT WITH NAMED INSURED	RESTRICTED (RE) TO NAMED INSURED'S OPERATION OR 24-HOUR (24)	Separate

V. SCHEDULE OF MEDICAL PROFESSIONALS - CRNAs, NURSE MIDWIVES, CRNPs, PODIATRISTS, PHYSICIAN ASSISTANTS AND SURGICAL ASSISTANTS

IF SHARED LIMIT OR SEPARATE LIMIT COVERAGE IS BEING REQUESTED FOR CRNAS, NURSE MIDWIVES, CRNPS, PODIATRISTS, PHYSICIAN ASSISTANTS AND / OR SURGICAL ASSISTANTS OR OTHER HEALTHCARE PROFESSIONALS, PLEASE PROVIDE THE INFORMATION BELOW. IF SEPARATE LIMITS COVERAGE IS DESIRED, ALSO SUBMIT AN APPLICATION FOR EACH INDIVIDUAL THAT COVERAGE IS REQUESTED. CLASSIFICATION AND RATING WILL BE BASED ON INFORMATION PROVIDED ON THE APPLICATION.

IF CLAIMS MADE COVERAGE IS BEING REQUESTED, COVERAGE IS DESIGNED TO PROVIDE RETROACTIVE DATES EQUAL TO THE DATE OF EMPLOYMENT WITH THE NAMED INSURED ENTITY. (*) IF COVERAGE IS DESIRED FOR SERVICES PROVIDED PRIOR TO THE DATE OF THE EMPLOYMENT WITH THE NAMED INSURED, PRIOR ACTS COVERAGE WILL BE RATED AND QUOTED IN ADDITION TO THE SERVICES RENDERED ON BEHALF OF THE NAMED INSURED.

IF AN APPLICATION IS COMPLETED FOR AN INDIVIDUAL THAT CONFLICTS WITH THE INFORMATION BELOW, THE PROVIDER WILL BE SUBJECT TO RE-CLASSIFICATION AND RE-RATING BASED ON THE ACTIVITIES AND INFORMATION CONTAINED IN THE INDIVIDUAL APPLICATION.

Instructions For Completing Each Column

- #1) Employment Status: (C) Contract, (E) Employed or (F) Faculty
- #2) Specialty: CRNA, CRNP, Nurse Midwife, PA, Podiatrist, Surgical Assistant
- #3) If CRNP or PA, Does Individual Prescribe Medication? Indicate Yes or No.
- #4) If Claims Made coverage type, indicate retro date.
- #5) Date Of Employment With First Named Insured (FNI).
- #6) Full Time Equivalency (FTE) Calculate FTE by dividing the total # of hours of professional service per week by 40 hours.
- #7) License Number.
- #8) Coverage Scope: (RE) Restricted to Named Insured's Operation OR (24) 24-Hour coverage.
- #9) Limits: (SH) Shared or (SE) Separate.

Column #:	1	2	3	4	5	6	7	8	9
Name of Medical Professional	(C), (E) or (F)	Specialty	Prescr. ? Yes/No	If CM, Retro Date	Date Of Empl. With FNI	FTE	License #	(RE) OR (24)	(SH) or (SE)