PROFESSIONAL LIABILITY APPLICATION
for
DIAGNOSTIC IMAGING SERVICES

INSTRUCTIONS: ANSWER ALL QUESTIONS; APPLICANT'S NAME MUST INCLUDE THE NAMES OF ALL BUSINESSES AND LOCATIONS FOR WHICH COVERAGE IS DESIRED.
If the answer is NONE, state NONE;
If the answer is NOT APPLICABLE, state NOT APPLICABLE (N/A).
If the space provided is insufficient to fully answer the question, PLEASE ATTACH A SEPARATE SHEET.
NOTE: APPLICATION MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

PART I. GENERAL INFORMATION

1.1 Applicant Name (including dba's): ______________________________
1.2 Mailing Address: ______________________________
1.3 Location Address(es): ______________________________
____
1.4 County (parish) of each location: ______________________________
1.5 Telephone Number: Office ___/___________ Fax ___/___________
1.6 Person to contact for survey: Name: ______________________________
Title: ______________________________
1.7 Year entity established: ______________________________
1.8 Entity is: ___ Individual ___ Sole Proprietorship ___ Partnership ___ Corporation
___ Professional Association/Corporation ___ Other. (Describe) ______________
1.9 Entity is: ___ For Profit ___ Non-Profit (Describe source of funds): ______________
1.10 Proposed effective date: ______________________________
1.11 Requested Limits of Liability (if available):
Professional Liability $ ____________ incident/ $__________aggregate
General Liability $ ____________ occurrence/ $__________gen. agg.
1.12 Annual Gross Receipts: Estimated next twelve months - $ ______________
Last twelve months - $ ______________
1.13 Annual Remuneration: Estimated next twelve months -$ ______________
Last twelve months - $ ______________
1.14 Total Premises Square Footage Occupied by Applicant: ______________
1.15 Off Premises Services Provided (describe______________________________
____

PART II. EXPOSURES

2.1 Describe fully the operations, activities, services and professional procedures administered:
____
____
____

2.2 STAFF : _____ Number of Full Time _____ Number Professionals ** _____ Number W-2

_____ Number of Part Time _____ Number Non-Professional _____ Number 1099

2.3 Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf? ______Yes ______No

Complete Below for ** Professional (W-2 and Ind. Contr. 1099) Staff
Number/FTE

__/___ Physicians-employed (other than Medical Director)*
__/___ Physician-contract (attach copy of contract)*
__/___ X-Ray Technician
__/___ Technician Trainee
__/___ Other (Describe) ________________
__/___ Other (Describe) ________________

* If any, please complete Physician's Exposure Supplement.

NOTE: ALL **PHYSICIANS** (EMPLOYEE, OWNER, CONTRACTOR, MEDICAL DIRECTOR, ETC) ARE REQUIRED TO HAVE INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE AT LIMITS EQUAL TO THE LIMITS REQUESTED HEREIN.

2.4 Is your facility owned by an M.D.? ___ Yes ___ No If yes, owner name(s)________________
If yes, indicate % of total services the owner's patient's tests represents: ________________%

2.5 Describe the referral source(s) by which patients are directed to the entity.________________

2.6 Number of estimated patient visits next twelve months__________last twelve months__________

2.7 Does your facility participate in any clinical trials or experimental procedures, equipment or product testing ? ___ Yes ___ No If yes, attach separate sheet describing the facility's involvement and a copy of the protocol, and any contracts involving same.

2.8 Does your facility own or operate any mobile diagnostic / imaging units ? _____ Yes _____ No
If yes, indicate the manufacturer / uses / sites used, and the gross receipts from each unit:__________

____

2.9 Indicate which of the following devices are utilized by your facility:

_____ CT Scanner _____ PET Scanner _____ SPECT _____Ultrasound
_____ MRI _____ MRI with ESR _____ (Other)________________
_____ Fluoroscope _____ X-Ray _____ (Other________________

2.10 Is cardiac catheterization performed at your facility ? _____ Yes _____ No
If yes, Specify (a) what equipment is utilized ________________
(b) who provides the cardiac monitoring ________________
(c) staffing of the catheterization lab and their qualifications, ________________
(d) are your catheterization staff members ACLS trained? _____ Yes _____ No,
(e) describe the protocol for treating medication reactions ________________and,
(f) list equipment/meds ready for handling of life threatening situations ________________

____

2.11 Are therapeutic procedures performed in your facility? _____ Yes _____ No
If yes, Indicate (a) whether each procedure is performed by a qualified M.D., or who performs the procedure ________________,
(b) who prescribes and sets dosage, and supervises the administration of the procedure __________
________________, (c) who calibrates, and what is the frequency of calibration, for the equipment utilized in the procedure ________________.

2.12 Does your staff **inject** any solutions, medications, contrast media into any patients? ____ Yes___ No
If yes, fully describe each substance and its usage, its storage and the number of dosages annually of each: ________________

____

2.13 Is a physician present to administer/supervise the injection of such substances? ____ Yes ____ No

2.14 Describe the protocol for treating adverse reactions: ________________

____

2.15 Describe the occupied building fully, including: _____ Own _____ Lease _____ Rent

Construction ______ Age of Bldg ______ Number Stories ______

Sq. Ft. Area ______ Wiring Type / Age ______ Prot. Class ______

Smoke Detectors # ______ Fire Alarm ______ Central ______ Local

Sprinklered ______ Fully ______ Partially Distance Nearest Fire Hydrant ______________

2.16 Does applicant provide any professional services under contract ? _____ Yes _____ No
If yes attach copy of contract (s) or samples if many are identical.

2.17 **Attach** copy of **letterhead**, service description / advertising **brochures / flyers**.

PART III. RISK MANAGEMENT

3.1 Name, qualifications and years of experience of the Medical Director, manager, supervisors:

Name	Title / Degree	Experience/Training	Assn. Membership

3.2 List applicant entity's memberships in professional organizations: ______________________________

3.3 Is the applicant eligible for certification or accreditation? ____ Yes ____ No
If yes, is applicant certified and/or accredited? ____ Yes ____ No
If no, explain the reason. ______________________________

3.4 Is the applicant and are all professional employees / contractors licensed in accordance with applicable state and federal laws? ____ Yes ____ No If no, explain ______________________________

3.5 Describe in detail your facility's policy and procedures for the supervision and transfer of temporary inpatient transfers where entity is responsible for the patient while on your premises: ______________

3.6 What equipment, etc. does your facility have readily available for handling life threatening situations?
____

3.7 Are tests / film results interpreted or diagnosed by applicant? _____ Yes _____ No
Are tests / film results interpreted or diagnosed by third party under contract to applicant to provide said service? _____ Yes _____ No
If Yes in either situation, who diagnoses / interprets ? ______________________________

Whose letterhead is used to send interpretations / results to client ? ______________________
If No, describe alternative arrangement, (i.e. statistical results only sent to client with no diagnostic interpretation or comment - client to provide own interpretation, or data sent to lab or other party of clients choosing for interpretation, etc) ______________________________

3.8 Are radiation meters worn by your professional staff? _____ Yes _____ No
If yes, are regular checks for exposure made? _____ Yes _____ No

3.9 Describe the patient screening process your facility utilizes for pregnancy, pacemakers, artificial valves, etc.______________________________

3.10 Does your facility require the professional staff to be CPR trained ? _____ Yes _____ No

3.11 Who performs the following in your facility?

a. Calibration of diagnostic equipment? ______ Contractor ______ Employee
b. Services/Maintains diagnostic equipment? ______ Contractor ______ Employee

If contractors perform either function, attach copy of contract. If employee, advise position and qualifications: ______________________________

3.12 Have there been any equipment failures/problems resulting in injury to a patient? ____ Yes ____ No

If yes, describe event(s) and steps taken to avoid recurrence ____________________

____

3.13 Do you have polices and procedures in place to report all applicable problems with medical devices to the Federal Drug Administration? ______ Yes ______ No

3.14 Are logs kept of all servicing, maintenance, calibration of precision instruments?______ Yes ______No

3.15 Does applicant, or any agency or association on its behalf advertise its professional services in any manner other than a simple listing in the telephone directory? ______ Yes ______ No
If yes, attach a copy of all advertisements.

3.16 Has the applicant or any of its employees:
a) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital or professional association? ______ Yes ______No
b) Had any professional license refused, suspended, revoked, renewal refused or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? ______ Yes ______ No
c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ______ Yes ______ No
IF THE ANSWER TO 3.15 IS YES, PLEASE ATTACH A DETAILED EXPLANATION.

3.17 Please describe in detail any additional operations, business pursuits, joint ventures in which your facility is currently engaged which would fall outside the scope of typical imaging center operations. Give Name / Address / Description of Operations / Common Ownership: (or state NONE)__________

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PART IV. HISTORY

4.1 List prior professional liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Form Yes	Claims-Made Form No
1.							
2.							
3.							
4.							
5.							

If claims-made form, what is the most recent **retroactive date**?__________If Prior Acts coverage being requested by new applicant, Prior Acts supplemental application must be completed.

4.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, so state.

	Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Form Yes	Claims-Made Form No
1.							
2.							
3.							
4.							
5.							

If claims-made, what is the most recent retroactive date?____________________

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an

interest?_____ Yes _____ No If yes, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved (attach an additional sheet if necessary).________________________

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____

4.4 Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence? _____ Yes _____ No If yes, describe the event and indicate the reason for anticipation of a claim.

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____

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Mid-Continent General Agency, Inc. any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and applicant has not withheld any information calculated to influence the judgment of the insurance company in considering this application.

IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.

______________ ____

Date Applicant/Title