

Medical Testing Laboratory
PROFESSIONAL LIABILITY APPLICATION

NOTE: COMPLETION AND SUBMISSION OF THIS APPLICATION IS FOR THE PURPOSE OF SECURING A PREMIUM QUOTATION ONLY. NO COVERAGE WILL BE EFFECTED UNTIL RECEIPT OF WRITTEN INSTRUCTION AND PREMIUM PAYMENT. ANY SUBSEQUENT CONTRACT ISSUED WILL BE IN FULL RELIANCE UPON THE STATEMENTS AND REPRESENTATIONS MADE IN THIS APPLICATION (AND ATTACHMENTS HERETO) AND THIS APPLICATION WILL BE MADE A PART OF THE POLICY.

IF A POLICY IS ISSUED, IT WILL BE ON A CLAIMS-MADE BASIS. THE LIMITS OF LIABILITY AVAILABLE TO PAY JUDGMENTS OR SETTLEMENTS SHALL BE REDUCED BY AMOUNTS INCURRED FOR DEFENSE EXPENSES. AMOUNTS INCURRED FOR LEGAL DEFENSE SHALL BE APPLIED AGAINST THE APPLICABLE DEDUCTIBLE AMOUNT.

All Questions must be fully completed. If there is insufficient space to complete an answer, continue on a separate sheet of the Applicant's letterhead. If a Question is not applicable, state "N.A."..

SECTION I – GENERAL INFORMATION:

1. **Full Name of Applicant (include ALL Firm names, trade names or dba's under which the Applicant operates, including subsidiaries):**

2. **Internet Address:** _____

3. **Address of Principal Office (street, city, state, zip)**

4. **List all states in which Applicant operates:**

5. A) **Does the Applicant have any other office locations?** YES NO

If YES, list complete addresses on a separate sheet.

B) **Does Applicant have a location at a hospital or other medical premises?** YES NO

If YES, does Applicant lease a distinct area? YES NO

6 **Applicant is a:** Individual LLC Corporation: For profit Non-profit
 Partnership Joint Venture **Other (specify):** _____

Date Established: _____ (mm/dd/yy)

7 **Has the name of the Applicant ever changed or has there been any acquisition, consolidation, dissolution, merger or any other change in business organization during the past five (5) years?** YES NO

If YES, provide full particulars on a separate sheet, including all Firm names, in chronological order. Additionally, provide claims information (as per SECTION III) for all prior Firms.

8 **During the coming twelve (12) months, does the Applicant contemplate offering any services not currently offered, or any mergers or acquisitions?** YES NO

If YES, please explain: _____

9. Professional Activities and Specialties (describe): _____

10. State approximate % of gross income derived from the following (total should be 100%) :

_____ % Alcohol/Drug Testing	_____ % HIV (AIDS)
_____ % CT/CAT	_____ % Immunology
_____ % Cytology	_____ % MRI/fMRI
_____ % DNA	_____ % Occupational
_____ % Fertility/Pregnancy/Paternity	_____ % PET/SPECT
_____ % Hematology	_____ % STDs
_____ % Hepatitis	_____ % Sonography
_____ % Histology	_____ % ultrasound
_____ % other (describe) _____	_____ % X-ray
_____ % other (describe) _____	
_____ % other (describe)- _____	

11. Does Applicant own (wholly or in part), operate, or administer any hospital, nursing home, assisted living facility or other institution where medical services are customarily rendered? Yes No
If Yes, please provide details by separate attachment.

12. State sources and amounts of TOTAL GROSS REVENUE/RECEIPTS:

SOURCE	This Year: _____	Last Year: _____
Charitable Contributions:	\$ _____	\$ _____
Government Funding:	\$ _____	\$ _____
Fee for Service:	\$ _____	\$ _____
_____	\$ _____	\$ _____
TOTAL GROSS REVENUE:	\$ _____	\$ _____

Estimate of Total Gross Revenue for Next Year: \$ _____

13. Staff:

	<i>Independent</i>	
	<i>Employees</i>	<i>Contractors</i>
A. Principals, Partners, Officers, Directors:	_____	_____
B. Registered Nurse:	_____	_____
C. LPN/LVN:	_____	_____
D. Nurse Anesth.:	_____	_____
E. Nurses Aides:	_____	_____
F. Certified Lab Tech./Technologist.:	_____	_____
G. Certified Medical Assistant :	_____	_____
H. EEG/EKG Tech./Technologist:	_____	_____
I. X-Ray Tech./Technologist:	_____	_____
J. Phlebotomist:	_____	_____
K. Medical Tech./Technologist:	_____	_____
L. Radiation Therapist:	_____	_____
M. Inhalation Therapist:	_____	_____
N. Physicians Assistant :	_____	_____
O. Social Worker	_____	_____
P. Clerical/Administrative	_____	_____
Q. : Other (specify): _____	_____	_____
TOTAL STAFF:	_____	_____

14. a) Are all above individuals licensed in accordance with all applicable state and federal regulations?
 Yes No If No, please attach explanation.
- b) Have any of the above individuals had their licenses/certifications revoked/suspended, voluntarily surrendered or cancelled? Yes No If YES, please attach explanation
- c) Do you require any above personnel to maintain their own professional liability coverage?
 Yes No If Yes please list individuals and required limits:

If No, is coverage requested for above individuals? Yes No

15. Please attach explanation for any of the questions below answered "YES" (include #tests/procedures & gross revenue):

- | | |
|---|--|
| a. Test result interpretation in applicant's (lab) name? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Consultation in Applicant's (lab) name? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Therapy or any treatment procedures? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Blood Banking or blood storage | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Procurement of blood or its components? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Plasmapheresis procedures? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. Medical, Genetic or Drug research? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| h. any type of environmental analysis? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Manufacture, testing or dispensing of pharmaceuticals? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| j. Manufacture or sell laboratory equipment or supplies? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| k. experimental testing/procedures? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| l. solely mobile services? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| m. any services at malls/shopping centers, health fairs etc.? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| n. Intravenous transfusions? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

16. What hours/days a week do you operate: _____

17. Does applicant utilize a procedural and quality control manual? Yes No

If Yes, does applicant make sure that all employees have reviewed these? Yes No

18. Is lab inspected/certified/accredited by any governmental or medical association? Yes No

If Yes, please list on separate attachment along the certifications/inspection dates.

19. Does applicant use a reference lab? Yes No

If Yes, please answer the following:

a. What are the expected annual receipts for the reference lab? \$ _____

b. Name of reference lab: _____

c. Does reference lab hold applicant harmless? Yes No

d. Does applicant obtain written proof of insurance with minimum limit of \$1,000,000, for reference lab? Yes No

e. Does applicant require reference lab to name them as an additional insured and obtain proof of same? Yes No

20. Does applicant provide any service under contract? Yes No If Yes, please provide details or sample contract?

21. Have any physicians with a financial relationship to the applicant ever made any medical referrals to the applicant? Yes No "Financial relationship means all ownership or investment interests, compensation arrangements, medical directorships with applicant".

If Yes, please provide details, including name of physicians, financial relationship and type of referral.

22. Attach a list of all physicians providing service at this entity (employed or contracted) and-include:

NAME, SPECIALTY, SERVICES, %OF OWNERSHIP, BOARD CERTIFIED, INSURANCE CARRIER/LIMITS/EXPIRATION DATE, if LAB is Listed AS ADDITIONAL INSURED.

23. Have any employed or contracted personnel been subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital or professional association? Yes No

24. Have any employed or contracted personnel been convicted of an act in violation of any law or ordinance other than a traffic accident? Yes No

25. Please list Professional Liability Policies covering applicant over the past 5 years:

<u>Carrier</u>	<u>Expiration Date</u>	<u>Limits</u>	<u>Deductible</u>	<u>Annual Premium</u>

If above policies were CLAIMS MADE please provide current RETROACTIVE DATE:)

26. Has any Professional or General Liability claim or suit been brought in the past 5 years against the applicant or any predecessor in interest? Yes No If Yes, please supply 5 years currently valued Carrier loss runs

27. Is the applicant aware of any circumstance, which may result in any claim against the applicant, or any predecessor in business or present Partner, Officer or Principal? Yes No If Yes, please provide details by separate attachment. Has applicant reported this circumstance/incident to their current carrier? Yes No

28. Has any application for Professional Liability Insurance made on behalf of the applicant or any predecessor in business or present Partner, Officer of Principal ever been declined or has the insurance been cancelled or renewal refused? Yes No If Yes, please provide details by attachment.

Please include along with this application any required attachments/questionnaires, copy of your brochure or advertisements and income statement & balance sheet for most currently completed fiscal year.

Limits of Liability requested: _____ Deductible: _____

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell no the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made a part of the policy.

The applicant understands that any subsequent contract issued by the Company will be issued on a CLAIMS MADE FORM.

Signature of Applicant (Principal, Partner or Officer) _____

Title: _____

Date: _____



Apogee Insurance Group LLC
610.337.3200
610.337.2337(fax)
www.apogeeinsgroup.com

X-RAY/Nuclear Medicine QUESTIONNAIRE

1. What testing substance are ingested or injected into the patients? _____

2. Is there a likelihood of adverse reaction to the substances used? _____

3. What emergency medical procedures have you established in the event of such reactions? _____

4. Describe the system of delivery and disposal of radio-nuclides: _____

5. Indicate the frequency of testing of air and water discharge from the facility to ascertain local, state and federal standards of compliance: _____

6. What training is provided to your personnel? _____

7. Maintenance of equipment is provided by: In-house Manufacturer/Distributor
Contracted to outside firm
Other (describe) _____

How often is equipment serviced: monthly quarterly BI-annual annually

8. Do you maintain records of your tests/procedures/scans? Yes No If Yes, please describe: _____

9. Are all tests/procedures/scans done per a physician request? Yes No

10. What personnel perform the test/procedure/scan? _____
Do procedures require two personnel to be with the patient at all times? Yes No

11. Who reports the interpretation of the test/procedure/scans etc.? _____

12. Are the x-rays/scans sent along with the report? Yes No

13. Are the x-rays/scans sent out under the name of the applicant or in the name of the Radiologist? _____

14. Number of annual patient contacts for all tests/scans/procedures/x-ray services: _____

15. Do employees wear nuclear sensitive badges which warn of potential nuclear problems? _____