Ambulatory surgery centers
Application form

Applicant information

1. Applicant name:

2. Principal business address (attach separate sheet if more than one location):

3. Telephone:

4. Website:

5. Date established:

6. Applicant's practice is a:
   ☐ solo practitioner (unincorporated) ☐ solo practitioner (incorporated)
   ☐ corporation (for-profit) ☐ corporation (non-profit)
   ☐ partnership ☐ individual, employee of (provide name of employer):

7. Is the applicant owned or controlled by any other entity? Yes ☐ No ☐
   If Yes, please describe:

8. Is the applicant licensed accordance with all applicable state laws? Yes ☐ No ☐

9. Is the applicant accredited by any of the following?
   Joint commission Yes ☐ No ☐
   AAAASF Yes ☐ No ☐
   AAAHC Yes ☐ No ☐

10. Is the applicant Medicare certified? Yes ☐ No ☐

11. Please state sources and amounts of total revenue:

	Last 12 months	Next 12 months
Fee for services		
Product sales		
Other – specify:		
Total		

Operations/services

12. Please provide the number of projected procedures performed annually for all types below:
   a. Colonoscopy ☐ b. Endoscopy ☐
   c. Dental/oral ☐ d. General surgery ☐
   e. Podiatry ☐ f. ENT (otolaryngology) ☐
   g. Pain management ☐ h. Urology ☐

i.	Cosmetic/plastic surgery		j.	Ophthalmology (non-Lasik)	
k.	Bariatric		l.	Lasik	
m.	Gynecological		n.	Orthopedic	
o.	Manipulation under anesthesia (MUA)		p.	Neurosurgery/spine	
q.	Abortions		r.	Other (describe)	

13. Please check all types of anesthesia used:

☐ Local/topical ☐ Spinal/epidural
☐ Sedation ☐ Tumescent
☐ Nerve blocks ☐ General

14. Do you perform any services other than outpatient surgical procedures? Yes ☐ No ☐

If Yes, please describe:

15. Do you treat minors? Yes ☐ No ☐

If Yes, provide percentage of patients under the age of 18 years old:

16. Does any staff member of, or individual with ownership interest in, the entity referenced in Question 1. also have ownership interest in any medical products distributor (including any physician owned distributor)? Yes ☐ No ☐

17. Do you own or operate any business other than that described in question 7. above? Yes ☐ No ☐

18. Do you own, operate, or administer any inpatient or residential facility, including maintaining beds for post-operative overnight care at this facility? Yes ☐ No ☐

If Yes, please provide details:

Number of beds:

Staff details

19. Please indicate the number of employed and contracted staff:

Profession	Employed	Contracted
Anesthesiologist		
Certified registered nurse anesthetist		
Physician's assistant		
Nurse practitioner		
Surgical technician		
Registered nurse		
Physician/surgeon		
Podiatrist		

Imaging technician		
Medical assistant		
Chiropractor		
Other – specify		

a. Are all of the above registered or licensed in accordance with all applicable state laws? Yes ☐ No ☐
If No, please attach an explanation.

b. Do you require contracted staff to carry their own professional liability insurance? Yes ☐ No ☐

c. Do you maintain certificates of insurance to confirm such coverage? Yes ☐ No ☐

d. Has the applicant or have any of the above employees/contractors:
   i. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes ☐ No ☐
   ii. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes ☐ No ☐
   iii. ever been treated for alcoholism or drug addiction? Yes ☐ No ☐
   iv. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes ☐ No ☐

If Yes, to any of the above, please attach an explanation.

20. Do all surgeons performing direct patient care services maintain separate medical malpractice coverage extending to these services? Yes ☐ No ☐
If Yes, please confirm the minimum limit of professional liability insurance required:

Each claim ____________ Aggregate: ____________

If No, please submit a physician supplemental application and C.V. for each physician to be included for coverage.

21. Do all anesthesiologists and CRNAs maintain separate medical malpractice coverage extending to these services? Yes ☐ No ☐
If Yes, please confirm the minimum limit of professional liability insurance required

Each claim ____________ Aggregate: ____________

22. Please confirm types of staff screening performed prior to hiring (check all that apply):

	Employee	Contractor
Background checks	☐	☐
License verification	☐	☐
Reference checks	☐	☐
Drug testing	☐	☐
National practitioner data bank check	☐	☐

Risk management

23. Are informed client consent forms used with all patients prior to treatment? Yes ☐ No ☐

Do you follow the Joint Commission Universal Protocol for preventing wrong site, wrong procedure incidents? Yes ☐ No ☐

If No, please provide detail on the protocol used to prevent ‘never events’.

24. Please describe your protocol in the event of complications or an emergency (or attach relevant written protocol used).

25. Provide the name and distance (in miles) of the hospital with which you have a written transfer agreement:

Name

Distance

26. Are all patients discharged by a physician? Yes ☐ No ☐

27. Do you have a formal peer review process? Yes ☐ No ☐

28. Are all patient screened to determine ASA physical status prior to treatment? Yes ☐ No ☐

29. Do you perform procedures on patients with an ASA risk score of three or higher? Yes ☐ No ☐

If Yes, please provide details:

30. Are all CRNAs supervised by an anesthesiologist while administering anesthesia? Yes ☐ No ☐

Insurance and claims history

31. Has any similar insurance ever been declined or cancelled? Yes ☐ No ☐

If Yes, please explain in the comments section.

32. Does any person to be insured have knowledge or information of any act, error or omission which might reasonably be expected to give rise to a claim against him/her? Yes ☐ No ☐

If Yes, please attach complete details including a description of the incident(s).

33. After inquiry have any professional or general liability claims been made against any proposed insured(s) during the past five (5) years? Yes ☐ No ☐

If Yes, please complete a supplemental claim form for each claim.

How many claims have been made in the last five (5) years?

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34. a. List prior professional liability insurers for the past five years (if none, please tick box) ☐

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim/ aggregate	Deducti ble	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

35. a. Is the applicant currently insured under a commercial general liability policy including products and completed operations coverage? Yes ☐ No ☐

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim/ aggregate	Deducti ble	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

Comments section

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It is understood and agreed that with respect to questions 18. and 19., that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage.

Notice to New York applicants: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material thereto, commits a fraudulent insurance act, which is a crime.

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the Underwriters.

Name of applicant:	
Signature of person authorized to execute on behalf of the applicant:	
Name/title of person authorized to execute on behalf of the applicant:	
Date:	

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated. Signing of this form does not bind the applicant or the Underwriters to complete this insurance.

A copy of this application should be retained for your records.