E. A. KELLEY COMPANIES

MISCELLANEOUS MEDICAL
PROFESSIONAL LIABILITY APPLICATION
(CLAIMS-MADE FORM)

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 DEDUCTCIBLE 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. **Address of Principal Office:**
____
____
____

3. Internet Address:____

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

5. Does the Applicant have any other office locations? []YES []NO
If *YES*, list complete addresses on a separate sheet.

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:

[] Home Healthcare Agency #Home Health Visits annually:__________
[] Medical/Testing Laboratory # tests annually:__________
[] Nurses Registry average length of placement:__________
[] Out-Patient Medical Clinic #outpatient visits annually:__________
[] Out Patient Mental Health Clinic #outpatient visits annually:__________
[] Residential Healthcare Facility #Beds:__________
[] Residential Mental Health Facility #Beds:__________
[] Referral Agency # calls annually:__________
[] Emergency Call Center/ Crisis Hotline #calls annually:__________

[] other:______________________________

____

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

_____% Alcohol Abuse Counseling
_____% Drug Abuse Counseling
_____% Mental Health Counseling/Evaluations
_____% Family Counseling
_____%Physical/Occupational/Speech Therapy
_____% Blood/Urine Testing (Drug/Alcohol)
_____% Referrals
_____% Methadone Maintenance
_____% Diagnostic Testing
_____% Pre-Employment Testing
_____% DUI classes
_____% Inpatient Detox
_____% Mental Health Group Home
_____% Hospice
_____% Halfway House
_____% Supervised Living
_____% Adoption/Foster Care
_____% Recreation Programs
_____% Training

_____% other:______________________________

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**:

SOURCE	Present Year	**Previous Year**
Charitable Contributions:	$__________	$__________
Government Funding:	$__________	$__________
Fee for Service:	$__________	$__________
__________	$__________	$__________
TOTAL GROSS REVENUE:	$__________	$__________

Estimate of Total Gross Revenue for next Year: $______________________________

13. Staff:

	Employees	Independent Contractors
Principals, Partners, Officers, Directors:	___________	___________
Registered Nurse:	___________	___________
LPN/LVN:	___________	___________
Nurse Anesth.:	___________	___________
Nurses Aides:	___________	___________
Certified Lab Tech./Technologist.:	___________	___________
Certified Medical Assistant :	___________	___________
EEG/EKG Tech./Technologist:	___________	___________
X-Ray Tech./Technologist:	___________	___________
Home Health Aide:	___________	___________
Medical Tech./Technologist:	___________	___________
Radiation Therapist:	___________	___________
Inhalation Therapist:	___________	___________
Speech Therapist:	___________	___________
Rehabilitation Therapist:	___________	___________
Physical Therapist	___________	___________
Physiotherapist:	___________	___________
Occupational Therapist:	___________	___________
Sports Medicine Therapist:	___________	___________
Phlebotomist:	___________	___________
Perfusionist:	___________	___________
Psychotherapist/Psychologist:	___________	___________
Social Worker:	___________	___________
Physicians Assistant:	___________	___________
Clerical/Administrative:	___________	___________
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) Do you required any of the above individuals to maintain their own professional liability coverage?
[] Yes [] No If Yes please list indiviudals 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":

Has the applicant or have any of the above employees ever:

a) Been the subject of disciplinary or investigative proceedings or reprimanded by a governmental or administrative agency, hospital or professional association? [] Yes [] No
b) Been convicted for an act committed in violation of any law or ordinance other than a traffic offense? [] Yes [] No

c) 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

d) Been treated for alcoholism or drug addiction? [] Yes [] No

16 Does applicant perform:

a)	Abortions?	[] Yes [] No
b)	Acupuncture or acupuncture anesthesia?	[] Yes [] No
c)	Angiography/Artiography/Venography?	[] Yes [] No
d)	Biopsies or endoscopies?	[] Yes [] No
e)	Catheterization (other than urinary/umbilical)?	[] Yes [] No
f)	Circumcisions ?	[] Yes [] No
g)	Closed reduction of compound fractures?	[] Yes [] No
h)	Cosmetic or Plastic Surgery?	[] Yes [] No
I)	Cryosurgery?	[] Yes [] No
j)	Dermabrasion?	[] Yes [] No
k)	Excision of large cysts and/or deep-seated boils or carbuncles?	[] Yes [] No
l)	Hysterectomies?	[] Yes [] No
m)	Injection of radioisotopes and/or irradiated substances?	[] Yes [] No
n)	Insertions of temporary pacemakers?	[] Yes [] No
o)	Laser Treatments?	[] Yes [] No
p)	Liposuctions	
q)	Normal/High Risk Deliveries and/or Caesarian Sections?	[] Yes [] No
r)	open reduction of fractures?	[] Yes [] No
s)	Psychiatric shock therapy?	[] Yes [] No
t)	Radiation Therapy and/or Chemotherapy?	[] Yes [] No
u)	Sex change operations?	[] Yes [] No
v)	Silicone Injections or Implants?	[] Yes [] No
w)	Spinal Injections?	[] Yes [] No
x)	Sterilizations?	[] Yes [] No
y)	Surgery for weight reduction of patients?	[] Yes [] No
z)	Surgery other than incision of superficial boils or suturing superficial fascia?	[] Yes [] No
aa)	Tonsillectomes or Adenoidectomies?	[] Yes [] No
bb)	**other Surgery (describe:____)**	[] Yes [] No

17. Does the applicant perform hospital emergency room care:

for its own regular patients? [] Yes [] No
for patients not its own? [] Yes [] No
if answer to b) is Yes, please specify the percent of time devoted to this work?__________% and the number of hours devoted to this work____________hrs.

18. Does the applicant prescribe drugs for weight reduction of patients? [] Yes [] No
Please list drugs prescribed on a separate attachment.

19. Do applicant or others administer anesthesia (other than topical or by means of local infiltration)?
[] Yes [] No **If *Yes*, please attach detailed explanation.**

20. **Does applicant maintain any beds for overnight occupancy? [] Yes [] No If *Yes*, please include # beds licensed and type of care provided on separate attachment.**

21. **If application is a training school, complete the following or [] Not Applicable**:

Profession for which student is being trained	Maximum # students per session	# of sessions per year	hrs that involve # of clinical settings students	Qualifications of Faculty (MD.etc)

SECTION II - Current Insurance

22. General Liability: Carrier:________________ Term:________________

Limits: Occurrence:________________Products/Co.Ops Agg:________________
General Agg:________________ Deductible:________________
Is coverage occurrence? [] Yes [] No Retroactive Date:________________

23. Professional Liability: (provide coverage for last 5 years)

Carrier	Limit Deductible		Premium	Expiration Date

If expiring coverage is claims made please provide Retroactive Date:________________

SECTION III - Claims History

24. **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.**

25. **Has any claim ever been made against the applicant or any of its employees? [] Yes [] No If *Yes*, please provide on separate attachment the following information for each situation or include currently values** loss runs for last 5 years.
1) Claimant's name 2) date when claim was reported 3) date when the loss or damage occurred 4) allegations of claim including amount of damages alleged 4) Reserved or Paid Expenses; Reserved or Paid Indemnity. 5) Final Disposition.

26. **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.**

*******Please include along with this application: 1) Brochures 2) Currently valued loss runs if available

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 to 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: ___________________________

SUPPLEMENT TO
Miscellaneous Medical Professional Liability
Application

Ambulatory Surgical Facility Supplemental Information Sheet

1. Is the facility licensed and/or accredited by any agency? Yes No

   If yes, please indicate agency name ____

2. Is the patient's written authorization for the specific surgical procedure(s) and is the patient's written "informed consent" obtained prior to surgery? Yes No

   If no, please explain

   ____

3. Are the above referenced items made a part of the patient's clinical record and maintained at the facility? Yes No

4. Indicate the number of operating rooms in the facility: ___________

5. Indicate the number of recovery rooms (including number of beds) in the facility: __________

6. Is "overnight" stay permitted at the facility? Yes No

7. In the event of complications, what are the emergency handling procedures at the facility?
   ____
   ____

8. With what hospital(s) has the facility a "transfer agreement" for handling of emergency cases?
   ____

9. What is the travel time and distance (in miles) to this hospital? ________________________

10. Can at least one member of your staff initiate CPR and begin advanced life support?
    Yes No

11. Please indicate which of the monitors below are used in the facility during surgical procedures:
    - EKG
    - Precordial Stethoscope
    - Blood Pressure Device
    - Other
    - Ability to monitor temperature (for general anesthesia)
    - Oxygen analyzer (for general anesthesia)

12. Do you have a back-up power system? Yes No

13. Please indicate if any of the following equipment is used in the facility:
    - Suction adequate for tracheal suctioning
    - A source for delivering oxygen throughout a surgical procedure
    - Equipment for endotracheal intubation
    - A defibrillator

14. Do you have drugs and supplies for treating cardiopulmonary emergencies? Yes No

15. If general anesthesia is used at the facility, are drugs and supplies readily available to initiate the treatment of malignant hyperthermia? Yes No

16. Please check each type of anesthesia care that is used at the facility:
    - Local anesthetic and minor regional blocks (e.g. digital nerve block)
    - Conscious sedation/analgesia (see last page for definition)
    - General anesthesia (see last page for definition)
    - Major regional anesthesia:
        - Interscalene
        - Supraclavicular
        - Axillary
        - IV regional
        - Spinal
        - Epidural
        - Other: ______________________________

17. Please indicate who provides sedation/analgesia/anesthesia at your facility:
    - Surgeon
    - CRNA
    - RN
    - Anesthesiologist
    - Surgical Assistant
    - Other: ______________

18. Please indicate whether children will have surgical procedures performed at your facility:
    - Children under 5 years of age
    - Children over 5 years of age

19. Please indicate the health status of patients who will have surgical procedures at your facility:
    - Healthy patients only (i.e. patients with absolutely no systemic disease)
    - Patients with mild systemic diseases (e.g. mild HTN)
    - Patients with more severe systemic diseases who are stable (e.g. well-compensated CHF)

20. Please provide a list of all physicians who have been granted privileges to perform procedures at the facility and indicate their medical specialty. Also, confirm that they have hospital privileges to perform all procedures.

21. Have all privileges been granted to other licensed health care providers? (e.g. dentist, podiatrist, etc.)
    Yes No

    If yes, please indicate type of professional(s): ______________________

22. Please attach a copy of a current listing of all procedures performed in the facility.

23. Please attach a copy of a patient brochure, if available.

______________________ Signature

______________________ Date

______________________ Name (please print)

______________________ Title

ANESTHESIA DEFINITIONS

For purposes of this questionnaire, the following are the definitions used relating to anesthesia:

***LOCAL ANESTHESIA** - The elimination of pain in one part of the body by the topical application or regional injection of a local anesthetic medication.

***ANALGESIA** - Results in the reduction of sensitivity to pain without loss of consciousness.

***CONSCIOUS SEDATION**- results in a minimally depressed level of consciousness that allows the patient to continually maintain an airway without assistance and respond quickly and appropriately to physical stimulation and verbal command. Protective reflexes are maintained. Conscious sedation can be achieved by oral (e.g. oral valium), inhalational (e.g. nitrous oxide), intramuscular or intravenous routes. Sedatives, narcotics and nitrous oxide are commonly intramuscular, or intravenous routes. Sedatives, narcotics, and nitrous oxide are commonly used drugs and are required in only low doses.

***DEEP SEDATION**- a controlled state of depressed level of consciousness accompanies by potential for partial or complete loss of protective reflexes, potential need for airway assistance, and diminished ability to respond appropriately to physical stimulation and/or verbal command. Deep sedation can be achieved by the same routes and drugs as conscious sedation using higher doses.

***GENERAL ANESTHESIA**- a controlled state of unconsciousness accompanied by loss of protective reflexes, inability to independently maintain an airway, and inability to purposefully respond to physical stimulation or verbal command. General anesthesia commonly involves combinations of intravenous sedatives, narcotics, and neuromuscular blockers along with inhaled "volatile anesthetics" and nitrous oxide. However general anesthesia may be induced simply by utilizing a large does of any of the medications used for sedation (for example, sodium thiopental or midazolam).