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Application

MEDICAL FACILITIES AND PROVIDERS MEDICAL LABORATORY SUPPLEMENTAL APPLICATION

This Supplemental Application is part of the Medical Facilities and Providers Liability Application.

A. ACCOUNT INFORMATION

1. Applicant Name (as identified in the Medical Facilities and Providers Liability Application):	

B. FINANCIAL AND EXPOSURE DETAILS

2. List the total number of tests performed in the following categories:

Laboratory Service/Testing Categories	Total Number of Tests Current Year	Total Number of Tests Projected Next 12 Months	Revenues for Current Year	Revenues Projected Next 12 Months
Chemistry, Hematology, Endocrinology, Coagulation, Toxicology, Urinalysis, Immunology, Parasitology				
Microbiology, Virology, Molecular, Diagnostics				
Pathology, Cytology, Histology				
Forensic Testing				
Genetic Testing				
Pap Smear				
Paternity Testing				
Reproductive Testing				
Surgical Biopsies				
Research				
Other (Describe): ____________				

C. OPERATIONS AND ADMINISTRATION

3. Does the Applicant re-screen 100% of negative PAP smears? ☐ Yes ☐ No

   If “No,” provide the % re-screened ________ %

4. What is the daily workload limitation for each cytotechnologist interpreting PAP smears? ____________

5. Does the Applicant’s staff perform venipuncture? ☐ Yes ☐ No

6. Has there been any change in the services offered by the Applicant's facility in the past 12 months? ☐ Yes ☐ No

If "Yes," provide details:

7. What percentage of the Applicant's facility's work is outsourced to other laboratories ________ %

8. List the other Laboratories utilized:

Name	Location (City/State)	Services Performed	Hold Harmless Agreement?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

9. Does the Applicant's facility contract with couriers to pick up specimens? ☐ Yes ☐ No

10. Does the Applicant's staff transport specimens in facility owned vehicles? ☐ Yes ☐ No

11. Does the Applicant have electronic tracking systems for all specimens that are processed? ☐ Yes ☐ No

12. Are there any circumstances when the test results are reported directly to the patient? ☐ Yes ☐ No

If "Yes," provide details:

13. Please check those certifications/accreditations held by the Applicant and provide the effective date(s):

☐ CLIA Date: ________ ☐ College of American Pathologists (CAP) Date: ________

☐ SAMHSA Date: ________ ☐ Other Accreditation(s) if any: ________ Date: ________

14. Has the Applicant had any CLIA sanctions in the last five years? ☐ Yes ☐ No

If "Yes," please explain:

D. SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplemental Application and any attachments of information submitted with this Supplemental Application are true and complete. The undersigned understands that information submitted herein becomes part of the Applicant's Medical Facilities and Providers Liability Application and is subject to the representations and conditions set forth therein.

NOTICE: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

NOTE: THIS APPLICATION MUST BE SIGNED BY THE CHIEF EXECUTIVE OFFICER, PRESIDENT, CHAIRMAN OR OTHER OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE.