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Application

MEDICAL FACILITIES AND PROVIDERS SCHOOLS 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. Student and Faculty – Indicate the number in each applicable category:

Course/Program Description:	Total Number of Students Enrolled	Total Number of Faculty	Total Hours: Clinical/Classroom	Total Hours: Clinical Only	Length of Program (Number of Years)
Allied Health School Describe: _____					
EMT School					
Nursing – Registered Nurses					
Nursing – LPN					
Nursing – Nurses Aide					
Nursing – Advanced Practice Nurse / Nurse Specialist					
Nursing – Other Describe: _____					
Optometry School					
Pharmacy School					
Physical Therapy					
Physician Assistant					
Advanced Training to Previously Licensed Professionals Describe: _____					
Other – Describe: _____					
Other – Describe: _____					
Other – Describe: _____					
Other – Describe: _____					

C. OPERATIONS AND ADMINISTRATION

3. Do the students participate in any of the following:

   a. Invasive Surgical Procedures ☐ Yes ☐ No

   b. Direct hands-on patient care ☐ Yes ☐ No

   c. Medication Administration ☐ Yes ☐ No

   d. Medical Record Documentation ☐ Yes ☐ No

   e. Observation ☐ Yes ☐ No

   Describe any "Yes" responses:

4. Does the faculty supervise students in the clinical setting? ☐ Yes ☐ No

5. Does the faculty provide direct patient care? ☐ Yes ☐ No

6. Does the Applicant require faculty medical professionals to carry Professional Liability of at least $1,000,000 Each Occurrence/$3,000,000 Aggregate? ☐ Yes ☐ No

   If "No," please explain:

7. Does the Applicant verify faculty Professional Liability insurance on an annual basis? ☐ Yes ☐ No

8. Where does the clinical portion of training take place?

   a. School owned facility ☐ Yes ☐ No

   b. Non school owned facility ☐ Yes ☐ No

   If "Yes," describe the non owned facility:

   Is there a mutual "hold harmless" agreement between the school and the facility? ☐ Yes ☐ No

9. Does the facility participate in Research Clinical Trials? ☐ Yes ☐ No

   If "Yes," describe these activities:

10. Does the Applicant provide any student health services, infirmary, or other healthcare services that it wants included for coverage? ☐ Yes ☐ No

    If "Yes," include services and visits on the Applicant's Medical Facilities and Providers Liability Application.

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.