Care Application Checklist

□ Complete Application

□ Completed claim form for every previous medical malpractice claim

□ Curriculum Vitae

□ Declaration sheet from your current carrier

□ Copy of your license(s)

APPLICANT'S INSTRUCTIONS:

1. Answer all questions; if a question is not applicable, state "NOT APPLICABLE".
2. If Space is insufficient to answer any questions fully, attach a separate sheet.
3. The Application must be signed and dated by the applicant.
4. It the answer to any question is none, state "NONE".
5. Please do not complete the application earlier than 60 days before proposed effective date of coverage.

Preparers Signature x_____ Date _____

Submitted by:
Agency: _____

Address: _____

City: _____ State_____ Zip _____

PROFESSIONAL LIABILITY ASSOCIATION, LLC

CARE RISK RETENTION GROUP, INC

URGENT CARE CENTER SUPPLEMENT

(THIS IS FOR A CLAIMS MADE AND ASSERTED POLICY)

1. A. Full Name of Facility _____

2. A. Principal Office Address

Street: _____

City/State/Zip: _____

County: _____ Phone # _____

Contact Person: _____Email _____

B. Mailing Address: (If different from Principal Office)

Street: _____

City/State/Zip: _____

County: _____ Phone # _____

3. A. Location #1

Distance to nearest hospital	
Date Location opened:	
Estimated # of annual patient visits	

Address	

B. Location #2

Distance to nearest hospital	
Date Location opened:	
Estimated # of annual patient visits	

Address	

C. Location #3

Distance to nearest hospital	
Date Location opened:	
Estimated # of annual patient visits	

Address	

Indicate which best describes your facility

❒ Urgent Care Center	Urgent care services are the primary activities performed by our organization. Physicians regularly staff your locations with the support of mid-level providers. Services provided are sometimes broader in scope than those typically found in a physician's office. Locations may offer a range of services including physical therapy, occupational therapy, occupational health (Workers Compensation exams), on site x-ray and clinical lab. No hospital admissions.
❒ Convenience Care Center	Locations are generally staffed by nurse practitioners and physician assistants. Physicians are not usually present at your locations. Medical treatment is typically offered at small offices with a limited level of non-emergent care relative to the physician's office.
❒ Other	Please provide a description of your organization if it does not readily reflect one of the above categories. Note the nature and extent of operations dealing with workers compensation and occupational medicine. Note any operations dealing with surgical procedures. Not if your operations more closely resemble a Primary Care facility, or if the facility works in conjunction with a Primary Care facility. (Please attach a separate page.)

Requested Effective Date:	Requested Retro Date:
Current Coverage for Professional Liability: ❒ Claims made; current retro date _____ ❒ Occurrence	

Applicant is a:	❒ Corporation	❒ Partnership	❒ Partnership Association
	❒ Sole Proprietorship	❒ Joint Venture	❒ Other (Please explain)

Limits of Liability: ❒ $250,000/$750,000 ❒ $1,000,000/$3,000,000 ❒ Other: (not all limits available in all states)
Has the applicant sold, acquired or discontinued any operations in the past ten years ❒ Yes ❒ No If yes, please explain: (Attach separate sheet if necessary)

	Physician Roster			
Physician Member	Employment Date	Hours Per Week Worked	Retro Date	Primary Location Worked

Please indicate all services provided by your facility, giving requested information for each classification. Information given should be projected for the next 12 months. Visits are defined as the number of patients treated at your facility.

Type of service provided; (Services listed are not limited to the examples used.)	**# of Visits Projected for Next 12 Months**	**# Visits for the Current Year**
Preventative/Diagnostic: This includes Corporate Health, Physicals, Immunizations, Allergy Shots, Alcohol/Drug Testing and Blood Pressure Screenings		
Non-Emergent Care: This includes Abrasions, Animal and Insect Bites, Minor Burns, Cough, Earaches, Flu, Minor Fractures, Minor Lacerations, Sore Throat and Sprains.		
Emergent Care: This includes Moderate/Severe Burns, Fractures, Allergic Reactions, Breathing Difficulties, Chest Pain or Pressure.		
Occupational Medicine dealing with workers compensation claimants.		

Clinical Operations

Please check any auxiliary services provided by your Urgent Care Center or any of its subsidiaries.

❒ Radiology	❒ Laboratory	❒ Pharmacy	❒ Treatment for chronic pain (complete supp.)
❒ PT/OT	❒ Family Practice	❒ Pre-surgical	❒ Medi-Spa
❒ Women's Health Services	❒ Pediatrics	❒ Other:	

If you have a Pharmacy or dispense samples, do you have a policy and procedure for dispensing, stocking and documentation?	❒ Yes ❒ No
If Yes, is the Pharmacy or samples dispensed by an automated system? Note: If "yes then no", please provide documentation (i.e. Bare Coding, connected to Electronic Medical Records, paper label system for medical charts, securing room and drug cabinets, documentation managing samples, etc.)	❒ Yes ❒ No

If you provide X-rays, are they digital?	❒ Yes ❒ No
Are your X-rays over-read by a Radiologist?	❒ Yes ❒ No
If "yes", are they : ❒ All reviewed ❒ Only certain types reviewed % Over Read: _____. Additional Details:	
If not over-read by Radiologist, does a Physician review 100% of the X-rays?	❒ Yes ❒ No
Is there an MD, DO, NP or PA-C onsite during all hours of operation?	❒ Yes ❒ No
Does the Urgent Care Facility or any of its subsidiaries participate in any experimental, investigational or other unconventional therapies including any alternative medicine activities?	❒ Yes ❒ No
Does the Urgent Care Facility or any of its subsidiaries participate in pharmaceutical testing programs/clinical investigation studies that are not FDA approved?	❒ Yes ❒ No
Does the Urgent Care Facility or any of its subsidiaries contract to provide services to any federal or non federal prisons?	❒ Yes ❒ No
Does the Urgent Care Facility of any of its subsidiaries contract to provide services to any nursing home or long term care facility?	❒ Yes ❒ No
Is triage performed by a MD, DO, NP, PA-C or RN?	❒ Yes ❒ No

Quality Assurance

Please indicate by checking the appropriate box(es) the accreditation(s) you facility currently has, if applicable.

❒ AAUCM	Most recent survey date:	❒ AAHC	Most recent survey date:
❒ JCAHO	Most recent survey date:	❒ NAFAC	Most recent survey date:
❒ UCAOA	Most recent survey date:	❒ AAAASF	Most recent survey date:

Please list any other accreditations and include the most recent survey date:

Is there a committee or provider in place that performs quality reviews?	❒ Yes ❒ No

Do your perform chart audits?	❒ Yes ❒ No
If "yes", how often do are audits performed	

If "yes", is there feedback given to the providers and staff?	❒ Yes ❒ No
If "yes", do the audits include specific high risk diagnosis reviews with feedback to the staff?	❒ Yes ❒ No

Are medical records reviewed against specific criteria on a regular basis?	❒ Yes ❒ No

Do any of the Physicians or Mid Level providers annually attend seminars, conferences or presentations that address risk reduction and patient safety?	❒ Yes ❒ No

Do you or a contracted company maintain your Medical Equipment QA logs and is the equipment checked per the manufacturer's recommendations?	❒ Yes ❒ No

If there is more than one location, do you have in place common P&Ps, PM and QA Plans?	❒ Yes ❒ No

Do you have an internal training program for your support staff and PAs? If "yes", please attach a description of this process.	❒ Yes ❒ No

What is the length of the orientation and training period for new employees and volunteers?	
Does it include training for the proper use of equipment and special training for high tech areas?	❒ Yes ❒ No

Do you utilize an Electronic Medical Record Keeping System?	❒ Yes ❒ No
If "yes", please identify the company:	

Do you utilize a crash cart?	❒ Yes ❒ No
If "yes", is there someone with ALS training on site during all hours of operation?	❒ Yes ❒ No

Do you have a defribulator on premises?	❒ Yes ❒ No

Are PA's supervised by on-staff Physicians?	❒ Yes ❒ No

How many PA's are currently on staff?	

Credentialing/Hiring Practices

Do the Credentialing/Hiring Policies ensure: Applications criteria are applied consistently	❒ Yes ❒ No
Primary sources verification is performed initially and at least every two years thereafter?	❒ Yes ❒ No

Please indicate all of the hiring/screening procedures used for professionals and allied healthcare professionals who provide patient care services at your facility:
❒ Check of educational background, or residency program, when applicable.
❒ Check of previous employers ❒ In Writing ❒ By telephone
❒ Check of personal references ❒ In Writing ❒ By telephone
❒ Check on hospital privileges for physicians, nurse practitioners and physician's assistants
❒ Perform criminal background checks
❒ Verify any pending license suspensions or revocations, or any pending disciplinary actions by other facilities
❒ Require information on any professional liability or work-related claim that has previously been made against any individual.

Are there written job descriptions for each category of employee and contractor?	❒ Yes ❒ No

Do you require that your Physicians and Mid Level Providers attend annual CE programs?	❒ Yes ❒ No

Are your Physicians Board Certified in Urgent Care Medicine, Emergency Medicine, Family Practice or Pediatrics?	❒ Yes ❒ No
If no, please describe:	

Patient Follow-up

Do you have a Patient Follow-up/Call-back Procedure? Please describe	❒ Yes ❒ No

Who is responsible for making the calls?		
What is the time frame for making calls?	❒ 24 Hours ❒48 hours ❒ Other	
Are there documentation requirements?		❒ Yes ❒ No
Are there parameters for physician communication?		❒ Yes ❒ No

Do you have a formal waiting time and patient satisfaction survey system?	❒ Yes ❒ No
If "yes", how often for each one:	
If "yes", do you use an Interactive Electronic Patient Satisfaction Survey System as the patient is leaving your care?	❒ Yes ❒ No

Loss History

Loss Description – On the attached Claims Questionnaire, please list any liability claims or suits made or brought against your facility or providers during the past five years.	
If no claims have been reported to you, then initial here:	
Have you received any communication/request for information and/or patient records from an attorney, a court of law, patient, patient family member, patient representative or any other outside party regarding medical services you performed **or** have any claims or suits for alleged malpractice been brought against you **or** are you aware of any circumstances, medical incidents or records requests that may give rise to a claim or a suit?	❒ Yes ❒ No

I hereby certify that as of the date of this application, all known claims or suits for incidents which occurred from the retroactive date as stated on Page 2 of this application to the date of the application have been reported to my current insurance carrier.

I also warrant that any and all acts, incidents and/or circumstances, of which I am aware, and which might reasonably be expected to result in a claim under the prior acts coverage afforded by any policy issued were disclosed to the Company prior to the effective date of such coverage and are listed previously or by supplemental form attached below.

WARRANTY

These warranties are material to the acceptance of coverage by the insurer, and are made a part of the insurance policy.

Further, I acknowledge and agree that any claims resulting from acts committed prior to the effective date of coverage, and of which I was aware, are specifically excluded from coverage under this policy and any applicable policy coverage excess of this policy.

Any binder of coverage issued by the Company as a result of this application is contingent upon compliance with applicable Federal/State Regulations, Company Underwriting Criteria and Risk Management Inspection regulations.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation through the use of any means legally available to the aforesaid entities, and I expressly release and discharge the aforesaid entities, their agents, employees and/or representatives from any and all liability which might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by the above-named entities or their duly authorized employees, agents, and/or representatives to provide the same with all information and/or documentation within their possession or under their control which pertains to my background, competence and qualifications.

ACKNOWLEDGED AND AGREED: _____

APPLICANT (Signature Required) _____ Date: _____

Signing this application does not bind any carriers to complete the insurance. All information requested in this application is considered material and important. If any carrier agrees to be bound under the terms of this application, your policy is void if you withhold any information from us, mislead us, or attempt to defraud or lie to us about any matter contained in this application.

PLEASE REVIEW THE POLICY CAREFULLY. Except to such extent as may be provided otherwise in the policy, the policy for which application is being made is limited to ONLY THOSE CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED while the policy is in force. Furthermore the policy includes the cost of defense of claims within the policy limit which means that the Policy limit available to pay a claimant WILL be reduced by the cost of investigation, defense and other expenses involved in the defense. The applicant, by signing this application below confirms (his/her) understanding of all provisions represented by the Insurer.

Signature of Applicant_____Date_____

Medical Malpractice Liability Application – Additional Information

Please include the following with your completed application:

1. Copy of the written discharge instruction for you use after patients have received your care.
2. List of providers, their specialties, retroactive dates, CV's, and loss statements.
3. Copy of current policy
4. Currently valued Medical Malpractice Loss Runs – Current and prior nine years (if applicable)
5. Complete claims questionnaire for each claim or incident (if applicable)

PROFESSIONAL LIABILITY ASSOCIATION, LLC

CARE RISK RETENTION GROUP, INC

Professional Liability Claims Information

(Must be printed or typed)

Complete one form for each case. Copies may be made as needed

Insurance Carrier: _____**Patient Name**_____

Date of Occurrence: _____ **Date of Suit**: _____

Location of Incident: _____

Relationship to Patient (attending physician, surgeon, consultant, etc.)

_____

Primary Defendant: _____ **Co-Defendant**: _____

Patient Outcome: _____

_____

Allegations made about care rendered: _____

_____

_____

_____

_____

Claim Status (Open, Closed, and Pending): _____ **Date**: _____

If closed, indicate method of closing: **(Circle below)**

DISMISSAL SETTLED JUDGMENT CASE-DROPPED

Amount of settlement/judgment: _____ Date: _____

Physician (print name): _____ Date: _____

I understand that the information submitted here becomes a part of my insurance application and is subject to the same representations and conditions.

Signature of Applicant: _____ Date: _____