500 Virginia St. E. Ste 1200
Charleston, WV 25301
P.O. Box 3697
Charleston, WV 25336-3697

Tel: 304.343.3000
Toll-Free: 888.998.7642
Fax: 304.342.0985
www.wvmic.com

**Agent Information**

Agency ______________________

Address ______________________

Producer ______________________

# LABORATORIES LIABILITY APPLICATION

Please complete the entire application. Indicate not applicable (N/A) where appropriate. Incomplete applications cannot be processed.

## PART I – ORGANIZATION INFORMATION

**A. CONTACT INFORMATION**

______________________
Applicant Name (Legal Corporation Name)

______________________ ______________________
Mailing Address, City, State, Zip Code — County

______________________
Street Address (If Different)

______________________ ______________________
Contact Person — Title

____-________ ____-________ ____-________
Business Phone — Business Fax — Residence Phone

______________________
Website Address

**B. REQUESTED COVERAGE EFFECTIVE DATE (12:01 AM):** ______________________

## PART II – GENERAL INFORMATION

**A. ARE THERE ANY PLANS FOR MERGERS, ACQUISITIONS OR CHANGES IN OWNERSHIP DURING THE NEXT 12 MONTHS?** ☐ Yes ☐ No

If yes, please explain: ______________________

**B. HOW MANY LOCATIONS DO YOU HAVE?** ____________

Please list all laboratory locations:*

**LOCATION #1**

STE STREET ____________ CITY ____________ STATE ______ ZIP CODE ______

Date this location opened? ____________ Estimated number of specimens at this location? ____________

**LOCATION #2**

STE STREET ____________ CITY ____________ STATE ______ ZIP CODE ______

Date this location opened? ____________ Estimated number of specimens at this location? ____________

**LOCATION #3**

STE STREET ____________ CITY ____________ STATE ______ ZIP CODE ______

Date this location opened? ____________ Estimated number of specimens at this location? ____________

***If more than three locations, please attach a separate page showing the additional locations.**

**C. DO YOU PLAN TO ADD ANY LOCATIONS DURING THE NEXT 12 MONTHS?** ☐ Yes ☐ No

If yes, please explain: ______________________

D. **LICENSES HELD BY YOUR FACILITY:** ______________________

E. **ANNUAL PAYROLL AND RECEIPTS:**
Total Annual Payroll: ______________ Total Projected Annual Receipts: ______________

## PART III – LABORATORIES FACILITY OPERATIONS

A. **ARE YOU OPERATING AS:**
- ☐ Clinical Pathology Lab (to include hematology, histopathology, cytology, routine pathology)
- ☐ Clinical Microbiology Lab (to include bacteriology, microbacteriology, virology, mycology, parasitology, immunology, serology, etc.
- ☐ Clinical Biochemistry Lab (to include biochemical analysis, hormonal assays, etc.)
- ☐ Blood Bank
- ☐ Research Lab

B. **DO YOU DO ANY OF THE FOLLOWING? IF SO, LIST THE NUMBER OF TESTS FOR THE MOST RECENT YEAR:**
- ☐ Pap Smear
- ☐ Surgical
- ☐ Forensic Testing
- ☐ Genetic Testing
- ☐ Paternity Testing
- ☐ Reproductive Testing
- ☐ Drug Testing

C. **DO YOU PROVIDE LABORATORY TESTING TO PATIENTS WITHOUT PHYSICIAN ORDERS?** ☐ Yes ☐ No
If yes, please explain: ______________________

D. **DO YOU COMPLY WITH THE STANDARDS AND/OR RULES SET FORTH BY CLIA FOR CYTOLOGY TESTING (TO INCLUDE PAP SMEARS, ETC.) WITH RESPECT TO WORKLOAD LIMITATION AND SPECIALIZED PROFICIENCY TESTING?** ☐ Yes ☐ No
If no, please explain: ______________________

E. **WHAT PERCENTAGE OF YOUR FACILITY'S WORK IS OUTSOURCED TO OTHER LABS?** __________%

F. **DO YOU HAVE AN ELECTRONIC TRACKING SYSTEM FOR ALL SPECIMENS THAT ARE PROCESSED?** ☐ Yes ☐ No
If no, please explain: ______________________

G. **ARE THERE ANY CIRCUMSTANCES WHEN TEST RESULTS ARE REPORTED DIRECTLY TO THE PATIENTS?** ☐ Yes ☐ No
If yes, please explain: ______________________

H. **DO YOU HAVE A MEDICAL REVIEW OFFICER?** ☐ Yes ☐ No

I. **DO ALL EMPLOYEES PARTICIPATE AT THE TIME OF HIRE AND IN REGULARLY SCHEDULED TRAINING REGARDING SAFETY AND OPERATION PROCEDURES?** ☐ Yes ☐ No
If no, please explain: ______________________

J. **DO YOU HAVE A WRITTEN SAFETY MANUAL USED BY ALL EMPLOYEES?** ☐ Yes ☐ No
If no, please explain: ______________________

K. **HAVE ANY SERVICES BEEN DISCONTINUED DURING THE LAST 24 MONTHS?** ☐ Yes ☐ No
If no, please explain: ______________________

L. **DO YOU HAVE REGULARLY SCHEDULED MAINTENANCE AND CALIBRATION OF ALL EQUIPMENT?** ☐ Yes ☐ No
If no, please explain: ______________________

M. **DO YOU HAVE A WRITTEN COMPLIANCE MANUAL DETAILING THE APPROPRIATE CLEANING AND HANDLING OF ALL SPECIMENS?** ☐ Yes ☐ No
If no, please explain: ______________________

N. **DO YOU HAVE A WRITTEN SYSTEM/PROCESS TO ASSURE LAB VALUES ARE SENT TO PROVIDERS IN A TIMELY FASHION?** ☐ Yes ☐ No
If no, please explain: ______________________

O. **DO YOU HAVE A WRITTEN SYSTEM/PROCESS FOR NOTIFICATION OF CRITICAL VALUES?** ☐ Yes ☐ No
If no, please explain: ______________________

P. **DO YOU HAVE A WRITTEN PROCEDURE FOR FOLLOW-UP IF PROVIDER IS UNAVAILABLE TO RECEIVE INFORMATION?** ☐ Yes ☐ No
If no, please explain: ______________________

Q. DO YOU HAVE A LABORATORY SOFTWARE SYSTEM THAT IS CAPABLE OF INTERFACING WITH THE LOCAL HOSPITAL(S) AND/OR OTHER LABS AND PROVIDERS? ☐ Yes ☐ No

If yes, please explain: ____________________

R. DO YOU HAVE A PROTOCOL FOR VERBAL ORDERS AND TELEPHONE REPORTING OF INFORMATION AND VALUES? ☐ Yes ☐ No

If no, please explain: ____________________

S. DO YOU PERFORM CONSULTATIONS OR INTERPRET TEST RESULTS FOR OTHER PHYSICIANS OR ORGANIZATIONS WHO RENDER MEDICAL PROFESSIONAL SERVICES IN ANOTHER STATE? ☐ Yes ☐ No

If yes, please explain: ____________________

T. DOES YOUR FACILITY CONTRACT WITH COURIERS TO PICK UP SPECIMENS? ☐ Yes ☐ No

If yes, please explain: ____________________

U. DOES YOUR STAFF TRANSPORT SPECIMENS IN FACILITY-OWNED VEHICLES? ☐ Yes ☐ No

V. DO YOU MAINTAIN OR TRANSPORT SPECIMENS IDENTIFIED AS SELECT AGENTS BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES OR THE UNITED STATES DEPARTMENT OF AGRICULTURE? ☐ Yes ☐ No

## PART IV – MEDICAL STAFF

**If shared limit or separate limit coverage is being requested for physicians, please provide the information below. Also submit an application for each individual that coverage is requested (shared limit or separate limit coverage) classification and rating will be based on information provided on the application.**

**If an application is completed for an individual that conflicts with the information below, the provider will be subject to re-classification and re-rating based on the activities and information contained in the individual application.**

A. PLEASE PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH PHYSICIAN THAT PRACTICES AT YOUR FACILITY.

| Name of Medical Professional | Employment Status: (C)ontract, (E)mployed, (F)aculty, (R)esident | Number of Procedures Performed at the Rehabilitation Facility | Indicate: Physician, Surgeon, Resident, Intern, or Fellow | Date of Employment With Named Insured | Restricted (RE) to Named Insured's Operation or 24-Hour (24) | Limits: Shared (SH), Separate (SE) |
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B. ARE EACH OF THE PHYSICIANS PRACTICING AT YOUR FACILITY BOARD CERTIFIED? ☐ Yes ☐ No

If no, how many are not board certified? ____________________

**C. PLEASE PROVIDE THE INFORMATION REQUESTED BELOW FOR EACH HEALTH PROFESSIONAL, OTHER THAN PHYSICIAN, THAT PRACTICES AT YOUR FACILITY:**

**INSTRUCTIONS FOR COMPLETING EACH COLUMN**

**#1) Employment status: (C) Contract, (E) Employed, or (F) Faculty.**
**#2) Specialty: CRNA, CRNP, Nurse Midwife, PA, Surgical Assistant.**
**#3) If CRNP or PA, does individual prescribe medication? Indicate yes or no.**
**#4) If claims made coverage type, indicate retro date.**
**#5) Date of employment with first Named Insured (FNI)**
**#6) License #.**
**#7) Coverage scope: (RE) restricted to Named Insured's operation or (24) 24-hour coverage.**
**#8) Limits: (SH) shared or (SE) separate.**

| Column# | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|---|---|---|---|---|---|---|---|---|
| Name of Medical Professional | (C), (E), or (F) | Specialty | Prescr. Yes/No | If CM, Retro Date | Date of Empl. With FNI | License # | (RE) or (24) | (SH) or (SE) |
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**D. DO YOU SUPERVISE ANYONE OTHER THAN YOUR OWN EMPLOYEES?** ☐ Yes ☐ No

If yes, please describe the responsibility of the individuals and what your relationships are to these individuals:

Also indicate, by type of medical professional, the number of individuals you supervise?

## PART V – RISK MANAGEMENT

**A. IS THERE A FORMAL RISK MANAGEMENT PROGRAM?** ☐ Yes ☐ No

**B. IS THERE A FULL-TIME RISK MANAGER?** ☐ Yes ☐ No

**C. WHAT IS THE NAME AND TITLE OF THE PERSON RESPONSIBLE FOR RISK MANAGEMENT?**

Name ______________________ Title ______________________

**D. IS THE RISK MANAGER RESPONSIBLE FOR REVIEWING INCIDENT REPORTS?** ☐ Yes ☐ No

**E. IS THERE AN ON-GOING QUALITY ASSURANCE (QA) COMMITTEE IN PLACE?** ☐ Yes ☐ No

1. If yes, is the person responsible for risk management a member of this committee? ☐ Yes ☐ No
2. To whom is the quality assurance accountable? ______________________
3. What quality indicators are monitored?
   Please List: ______________________
4. Do you monitor infection rates at your facilities? ☐ Yes ☐ No

**F. IS THERE AN ACTIVE PEER REVIEW PROCESS FOR PHYSICIANS THAT IS PART OF THE QUALITY MANAGEMENT TEAM?** ☐ Yes ☐ No

If no, please explain: ______________________

G. **IS THERE AN ON-GOING CONTINUING EDUCATIONAL PROGRAM FOR:**

Nursing Staff? ☐ Yes ☐ No
Other allied health professionals? ☐ Yes ☐ No

H. **NAME OF THE PERSON OUR RISK MANAGEMENT CONSULTANT MAY CONTACT FOR AN ON-SITE VISIT:**

Name ____________________ Title ____________________

## PART VI - CREDENTIALING

A. **WHEN HIRING PROFESSIONALS AND SUPPORT STAFF DO YOU:**

1. Verify educational background? ☐ Yes ☐ No
2. Check all references including past employers? ☐ Yes ☐ No
3. Check pending license suspensions, revocations, or disciplinary actions by other facilities? ☐ Yes ☐ No
4. Check criminal history? ☐ Yes ☐ No
5. Require prior medical professional claim history? ☐ Yes ☐ No

B. **ARE CREDITIALS OF EACH PHYSICIAN REVIEWED BY A MEDICAL STAFF COMMITTEE AND APPROVED BY THE GOVERNING BODY PRIOR TO GRANTING PRIVILEGES?** ☐ Yes ☐ No

C. **IS AN ONGOING QUALITY ASSURANCE REVIEW MAINTAINED ON ALL STAFF MEMBERS' CLINICAL WORK?** ☐ Yes ☐ No

D. **DO MEDICAL STAFF BYLAWS REQUIRE EACH PHYSICIAN WORKING AT YOUR FACILITY TO MAINTAIN PROFESSIONAL LIABILITY INSURANCE?** ☐ Yes ☐ No

1. If yes, what are the minimum limits of liability required? $ __________ / $ __________
2. Are Certificates of Insurance obtained at least annually from each individual to verify coverage is in place? ☐ Yes ☐ No

E. **WHAT ARE THE MINIMUM LIMITS OF LIABILITY YOU REQUIRE NON-PHYSICIAN MEDICAL PROFESSIONALS WORKING AT YOUR FACILITY TO CARRY?**

$ __________ / $ __________

Are Certificates of Insurance obtained at least annually from each individual to verify coverage is in place? ☐ Yes ☐ No

F. **HAS THE LICENSE OF ANY PHISICIAN BEEN RESTRICTED, REVOKED OR SUSPENDED IN THE LAST FIVE YEARS?** ☐ Yes ☐ No

If yes, please explain: ____________________

G. **HAVE YOU MADE REPORTS TO THE NATIONAL PRACTITIONER DATA BANK OF ANY PEER REVIEW ACTION, SUSPENSION OR PROFESSIONAL LIABILITY PAYMENT INVOLVING ANY MEMBER OF THE MEDICAL STAFF DURING THE LAST FIVE YEARS?** ☐ Yes ☐ No

If yes, please explain: ____________________

## PART VII – PHYSICAL PLANT

A.

| Address of property to be insured | Use/occupancy | Square footage | Age | Type of construction | Number of stories | Fire protection* |
|---|---|---|---|---|---|---|
| Patient Care Buildings: | | | | | | |
| | | | | | | |
| | | | | | | |
| Other Buildings: | | | | | | |
| | | | | | | |
| | | | | | | |

*For each building indicate if there is a: Sprinkler System – Full, Partial, or No Sprinkler
Smoke Detector, Heat Detector
Fire Alarm – Central Station or Local Alarm

B. **DO ALL FACILITIES COMPLY WITH THE NATIONAL FIRE PROTECTION ASSOCIATION (NFPA) 101 LIFE SAFETY CODE 2000 EDITION OR NEWER?** ☐ Yes ☐ No

If no, please explain: ____________________

## PART VIII – GENERAL LIABILITY

**DO YOU DESIRE GENERAL LIABILITY COVERAGE?** ☐ Yes ☐ No
**If yes, complete this section.**

**A. IS THERE A PREVENTIVE AND CORRECTIVE MAINTENANCE PROGRAM IN PLACE FOR THE BIOMEDICAL EQUIPMENT AND SURGICAL MACHINES OR DEVICES AT THE FACILITY?** ☐ Yes ☐ No

1. How often are non-expendable medical or surgical machines or devices inspected and maintained? ______________________
2. Who performs the maintenance on the above equipment? ☐ Employees ☐ Independent Contractors
3. If independent contractors, what are the minimum general liability limits that you require them to carry?
$ ____________ / $ ____________
4. Do you obtain a Certificate of Insurance annually to verify this coverage is in place? ☐ Yes ☐ No

**B. IS ANY OF THE BIO-MEDICAL EQUIPMENT USED AT YOUR FACILITY OWNED BY PHYSICIANS?** ☐ Yes ☐ No

If yes, who is responsible for the preventive maintenance, inspection and repair of the equipment?
______________________

**C. DO YOU LEND OR DONATE YOUR BIO-MEDICAL EQUIPMENT TO OTHERS FOR THEIR USE?** ☐ Yes ☐ No

If yes, please describe: ______________________

**D. DO YOU RENT OR LEASE MEDICAL EQUIPMENT FROM OTHERS?** ☐ Yes ☐ No

If yes, who is responsible for the maintenance of the equipment? ______________________

**E. DO YOU USE AN ADVERTISING AGENCY?** ☐ Yes ☐ No

1. If yes, what is the minimum professional liability limit that you require them to carry?
$ ____________ / $ ____________
2. Are you included as an additional insured on the advertising agency's policy? ☐ Yes ☐ No
3. Is there a hold harmless agreement in the contract in favor of your facility? ☐ Yes ☐ No

**F. ARE THERE ANY PLANS FOR NEW CONSTRUCTION OR RENOVATIONS DURING THE NEXT 12 MONTHS?** ☐ Yes ☐ No

If yes, please describe the changes planned including the time frame and the estimated cost:
______________________
______________________
______________________
______________________
______________________
______________________
______________________

**G. DO YOU LEASE OR RENT SPACE TO OTHERS?** ☐ Yes ☐ No

If yes, indicate the following:

City ____________ State ____________ Zip Code ____________

Square Footage ____________ Occupancy/Use of Space ____________

1. Does your lease require the tenant to carry general liability insurance with at least a $1,000,000 limit? ☐ Yes ☐ No
2. Do you obtain a Certificate of Insurance annually to verify this coverage is in place? ☐ Yes ☐ No
3. Is the tenant required to list you as an additional insured on their general liability policy? ☐ Yes ☐ No

## SPECIFIC CONSENT TO CONSIDERATION OF THE APPLICATION FOR INSURANCE

With the submission of this application for insurance, I accept the following conditions during the processing and consideration of my application, regardless of whether or not I am granted insurance, and for the duration of the insurance which may be issued to me:

To the fullest extent permitted by law, I extend absolute immunity to, and release WV Mutual Insurance Company, its directors, officers, agents, employees and other authorized representatives from any and all liability for any acts pertaining to my application for insurance, including ultimate cancellation, rejection, or approval for insurance, and any communications, reports, records, statements, documents or disclosures, including otherwise privileged or confidential information, made or given in good faith with respect to such application.

**I acknowledge that acceptance into the Company's insurance program is not a right of every applicant who makes an application for insurance, and that my application will be evaluated by authorized management personnel and/or the Company's Underwriting Committee.**

**Applicant's Signature** ______________________ **Date** ______________

## AGREEMENTS & NOTICES

**Notice to West Virginia Applicants:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Notice to Kentucky Applicants:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose on misleading , information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Notice to Ohio Applicants:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Notice to Virginia Applicants:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, denial of insurance benefits, and civil damages.

**Applicant's Signature:** ______________________ **Date:** ______________

**IMPORTANT:** Incomplete or incorrect information could require retroactive upward premium adjustment, and in the event of a claim, could lead to a denial of liability. Below is an Authorization to Release Information form which requires your signature.
Please read carefully.

## AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by WV Mutual Insurance Company (the "Company") hereby authorizes the applicant's present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Company upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Company may have a bearing upon the applicant's acceptability to the Company as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, the Company, its directors, officers, employees and agents from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing the information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Company and all persons and organizations described above may rely upon a photocopy of this Authorization, which shall be of equal validity with the undersigned original.

**Name:** ______________________

**Signature:** ______________________

**Date:** ______________________