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	

SURGERY CENTER 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 Name Title

________-________________ ____-________________
Business Phone Business Fax

____
Website Address

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

PART II – GENERAL INFORMATION

A. HOW MANY SURGERY CENTER FACILITY LOCATIONS DO YOU HAVE? ______________

If you have multiple locations, are all locations certified/accredited? ☐ Yes ☐ No

B. MEDICAL DIRECTOR:

____
Name of Medical Director

________ ______________ ______________________
Phone Number Email

C. ARE THERE ANY PLANS FOR MERGERS OR ACQUISITIONS DURING THE NEXT 12 MONTHS? ☐ Yes ☐ No

D. INDICATE THE NUMBER OF OUTPATIENT SURGERIES PERFORMED AT YOUR FACILITY:

During the last 12 months: ______________

How many do you expect to perform in the next 12 months? ______________

E. ANNUAL PAYROLL AND RECEIPTS:

Total Annual Payroll: ______________ Total Projected Annual Receipts: ______________

PART III – SURGERY CENTER OPERATIONS

A. **DO YOU HAVE ANY BEDS USED FOR OVER-NIGHT OCUPANCY?** ☐ Yes ☐ No IF YES, HOW MANY? ________
ARE ANY LICENSED AS ACUTE CARE HOSPITAL BEDS? ☐ Yes ☐ No IF YES, HOW MANY? ________

B. **DO YOU PROVIDE ANY POST-OPERATIVE SERVICES?** ☐ Yes ☐ No
If yes, please describe: ________________________________

What type of recovery care following discharge from the PACU do you provide? ☐ None ☐ 24-Hour Program ☐ 72-Hour Program

C. **DO YOU PROVIDE ANY PROFESIONAL SERVICES TO NON-PATIENTS (i.e., MEDICAL, LABORATORY, PHARMACY, RADIOLOGY, ETC.)?** ☐ Yes ☐ No
If yes, please explain and provide associated receipts or outpatient visits: ________________________________

D. **PLEASE DESCRIBE THE PROVISIONS THAT HAVE BEEN MADE FOR AFTER HOURS AND EMERGENCY CARE:**

____

E. **ARE ANY CHANGES PLANNED TO THE SERVICES OR SURGERIES YOU PLAN TO OFFER IN THE NEXT 12 MONTHS? (i.e., ARE YOU ADDING OR DISCONTINUING ANY SERVICES?)** ☐ Yes ☐ No
If yes, please describe: ________________________________

F. **HAVE ANY SERVICES OR TYPES OF SURGERIES BEEN DISCONTINUED DURING THE LAST 24 MONTHS?** ☐ Yes ☐ No

G. **HAVE YOU OR WILL YOU PROVIDE RESEARCH ACTIVITIES FOR PHARMACEUTICALS, SURGERY, BIOMEDICAL EQUIPMENT OR PSYCHOTHERAPY?** ☐ Yes ☐ No

H. **DO YOU HAVE THE FOLLOWING EQUIPMENT AT YOUR FACILITY:**
1. Crash cart with full cardiac life support capabilities and necessary IV fluids? ☐ Yes ☐ No
2. Defibrillator? ☐ Yes ☐ No
3. EKG? ☐ Yes ☐ No
4. Oxygen? ☐ Yes ☐ No
5. Suction? ☐ Yes ☐ No
6. X-ray with the ability to do on-premise processing? ☐ Yes ☐ No

I. **DO YOU HAVE WRITTEN POLICIES AND PROCEDURES THAT ADDRESS:**
1. Documentation of pre-operative care, intra-operative care and post-operative care? ☐ Yes ☐ No
2. Documentation of the performance of sponge and instrument counts in the medical record? ☐ Yes ☐ No
3. Documentation of the positioning of patients during surgery? ☐ Yes ☐ No
4. Dictation of operative report within 24 hours of surgery? ☐ Yes ☐ No
5. Phone call to the patient within 24 hours of discharge? ☐ Yes ☐ No
6. Documentation of a patient notification of abnormal pathology results in the medical chart? ☐ Yes ☐ No
7. How equipment and instruments are cleaned, disinfected and sterilized at your facility? ☐ Yes ☐ No

If no for items 1-7 above, please explain:

____

J. DO YOU HAVE A WRITTEN DISCHARGE POLICY IN PLACE THAT REQUIRES:

1. The patient be examined by a physician prior to discharge? ☐ Yes ☐ No
2. Written instructions (the original maintained in chart) including emergency care procedures be given to the patient upon discharge? ☐ Yes ☐ No
3. Someone other than the patient drives the patient home after the surgical procedure? ☐ Yes ☐ No

If no for items 1-3 above, please explain: ______________________________

____

____

____

K. DO YOU HAVE A WRITTEN EMERGENCY TRANSPORT POLICY AND AN AGREEMENT WITH A LOCAL HOSPITAL? ☐ Yes ☐ No

HOSPITAL PROVIDING EMERGENCY CARE:

____

NAME

____

ADDRESS

L. CATEGORIES OF SURGICAL PROCEDURES

Categories Of Surgical Procedures (List Others In Blanks Provided)	Indicate The Number Of Surgical Procedures That Were Performed At Your Facility During The Last 12 Months	Indicate The Number Of Surgical Procedures You Expect To Perform At Your Facility During The Next 12 Months
Cardiovascular		
Gastroenterology (Endoscopy, Colonoscopy, Etc.)		
Other Colon And Rectal		
General Surgery		
Gynecological		
Neurosurgical		
Obstetrical		
Orthopedic – No Spinal		
Orthopedic – Spinal		
Ophthalmology (Also See Lasik Question III.C.)		
Pain Management		
Plastic – Cosmetic (*)		
Otorhinolaryngology		
Urological		
Vascular		

(*) Please describe the specific cosmetic procedures being performed: ______________________________

____

____

____

____

SPECIFIC PROCEDURE INFORMATION

Please check any of the following procedures that you perform:

- ☐ Elective Abortions
- ☐ Acupuncture
- ☐ Adenoidectomy
- ☐ Anesthesia:
  - ☐ Spinal
  - ☐ Caudal
  - ☐ General
  - ☐ Local
  - ☐ Other: ______________________
- ☐ Angiography
- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Bariatrics
- ☐ Blepharoplasty
- ☐ Breast Implants
  - ☐ Cosmetic __________ % of Practice
  - ☐ Reconstructive __________ % of Practice
- ☐ Catheterization
  - ☐ Arterial
  - ☐ Cardiac
  - ☐ Diagnostic
  - ☐ Left Heart
- ☐ Chelation Therapy
- ☐ Chemonucleolysis
- ☐ Cholecystectomy
- ☐ Cholecystectomy / Laparoscopic
- ☐ Colonoscopy
- ☐ Cryosurgery (other than external lesions)
- ☐ D&C
- ☐ Dermatological Surgery:
  - ☐ Chemical Peels
  - ☐ Chemobrasion
  - ☐ Dermabrasion
  - ☐ Hair Transplants
  - ☐ Silicone Injections
  - ☐ Tumescent Liposuction
  - ☐ Other: ______________________
- ☐ Elective Plastic Surgery
- ☐ Encephalography
- ☐ Endoscopic Laser Therapy
- ☐ Endoscopy
- ☐ ERCP
- ☐ Fluoroscopy
- ☐ Fracture Reductions
  - ☐ Open
  - ☐ Closed
- ☐ Gastrointestinal Endoscopy
- ☐ Hip Nailings
- ☐ Hyperbaric Medicine
- ☐ Laparoscopy
- ☐ Laser Surgery
- ☐ Lasik Surgery
- ☐ Liposuction
- ☐ Lithotripsy
- ☐ Myelography
- ☐ Norplant Insertion/Extraction
- ☐ Obstetrics
  - ☐ Prenatal
  - ☐ Postnatal
  - ☐ Deliveries
- ☐ Organ Transplant
- ☐ Pain Management
  - ☐ Medicine Only
  - ☐ Nerve Block
  - ☐ Implants
  - ☐ Radiofrequency Procedures
  - ☐ Other: ______________________
- ☐ Pedicle Screws for Spinal Surgery
- ☐ Permanent Pacemaker
- ☐ Polypectomy
- ☐ Radiation/ X-Ray Therapy
- ☐ Radiopaque Dye Injection
- ☐ Renal Dialysis
- ☐ Sclerotherapy
- ☐ Shock Therapy
- ☐ Spinal Surgery
- ☐ Teleradiology
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Tubal Ligation
- ☐ Vasectomy
- ☐ Weight Control Surgery
  - ☐ Gastric Bubble
  - ☐ Gastric Stapling
  - ☐ Laparoscopic Banding
- ☐ Other Procedures: ______________________

____

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 FACIILITY:

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)

B. ARE EACH OF THE PHYSICIANS PRACTICING AT YOUR FACILITY BOARD CERTIFIED? ☐ Yes ☐ No

If no, how many are not board certified? ______________________________

C. DO YOU HAVE ANY PHSICIANS ON STAFF THAT DO NOT MAINTAIN STAFF PRIVILEGES AT A HOSPITAL? ☐ Yes ☐ No

If yes, please explain: ______________________________

D. **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)

E. **DO YOU SUPERVISE ANYONE OTHER THAN YOUR OWN EMPLOYEES?** ☐ Yes ☐ No

If yes, 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 – SERVICES INFORMATION

ANESTHESIA

A. **NUMBER OF ANESTHESIOLOGISTS:** ______________ **CRNA'S:** ______________

B. **ARE ALL ANESTHESIOLOGISTS REQUIRED TO BE BOARD CERTIFIED/ELIGIBLE IN ANESTHESIOLOGY?** ☐ Yes ☐ No

C. **ARE ALL CRNA's SUPERVISED BY AN ANESTHESIOLOGIST?** ☐ Yes ☐ No

D. **IS A PRE-ANESTHESIA EVALUATION DONE BY AN ANESTHESIOLOGIST?** ☐ Yes ☐ No

E. IS ANESTHESIA EQUIPMENT EQUIPPED WITH:
- OXYGEN-ANALYZERS? ☐ Yes ☐ No
- DISCONNECT ALARMS? ☐ Yes ☐ No

F. WHO OWNS AND MAINTAINS THE OXYGEN EQUIPMENT?

____

G. DO YOU TREAT CHILDREN? ☐ Yes ☐ No

H. WHAT ASA CATEGORIES ARE TREATED? _______________________

I. IS THERE A SEPARATE INFORMED CONSENT FOR ANESTHESIA? ☐ Yes ☐ No

J. DO YOU MONITOR THE USE OF REVERSAL AGENTS? ☐ Yes ☐ No

K. OTHER THAN ANESTHESIOLOGISTS OR CRNA's, LIST ANYONE WHO ADMINISTERS ANESTHESIA OR CONSCIOUS SEDATION:

____

PHARMACY

A. DO YOU OWN OR OPERATE A PHARMACY? ☐ Yes ☐ No
If yes, does a full-time registered pharmacist direct the pharmacy? ☐ Yes ☐ No

B. IS THE PHARMACY STAFFED AT ALL TIMES WHILE THE FACILITY IS OPEN? ☐ Yes ☐ No

C. DOES THE PHARMACY USE A BAR CODING SYSTEM OF DISPENSING MEDICINE? ☐ Yes ☐ No

D. ARE IV ADMIXTURES PREPARED BY A PHARMACIST ON SITE? ☐ Yes ☐ No

PART VI – RISK MANAGEMENT

A. IS THERE A FORMAL RISK MANAGEMENT PROGRAM ☐ 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 A WRITTEN INCIDENT REPORTING PROCEDURE? ☐ Yes ☐ No
If yes, does this procedure require review and appropriate corrective action be taken? ☐ Yes ☐ No
Is follow-up made to assure compliance? ☐ Yes ☐ No

F. 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 committee accountable?

Name _______________________ Title _______________________

3. What quality indicators are monitored (please list)? _______________________

____

4. Do you monitor infection rates at your facilities? ☐ Yes ☐ No

G. IS THERE AN ACTIVE PEER REVIEW PROCESS FOR PHYSICIANS WHICH IS PART OF THE QUALITY MANAGEMENT PROGRAM? ☐ Yes ☐ No
If no, please explain: _______________________

____

H. IS THERE AN ON-GOING CONTINUING EDUCATION PROGRAM FOR: Nursing staff? ☐ Yes ☐ No

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

Name ____________________ Title ____________________

PART VII - 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. Confirm hospital privileges for physicians and surgeons? ☐ Yes ☐ No
4. Check for pending license suspensions, revocations, or disciplinary actions by other facilities? ☐ Yes ☐ No
5. Check criminal history? ☐ Yes ☐ No
6. Require prior medical professional claim history? ☐ Yes ☐ No

B. **ARE CREDENTIALS FOR 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 last 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 last annually from each individual to verify coverage is in place? ☐ Yes ☐ No

F. **HAS THE LICENSE OF ANY PHYSICIAN 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 VIII – PHYSICAL PLANT

A. **PLEASE FURNISH THE FOLLOWING INFORMATION FOR ALL OWNED OR LEASED PROPERTY OPERATED OR OCCUPIED BY YOU. A SEPARATE SUMMARY OF LOCATIONS/EXPOSURES IS ACCEPTABLE, PROVIDED THE INFORMATION OUTLINED BELOW IS FURNISHED.**

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 ASSOCIATE (NFPA) 101 LIFE SAFETY CODE 2000 EDITION OR NEWER?** ☐ Yes ☐ No

If no, please explain: ____________________

PART IX – 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 BIO-MEDICAL 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 of the above equipment? ☐ Employee ☐ Independent Contractor
3. If independent contractor, 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, polease describe the changes planned including the time frame and the estimated cost:
____

G. DO YOU LEASE OR RENT SPACE FROM 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: ____