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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:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Pap Smear | <input type="checkbox"/> Genetic Testing | <input type="checkbox"/> Drug Testing |
| <input type="checkbox"/> Surgical | <input type="checkbox"/> Paternity Testing | |
| <input type="checkbox"/> Forensic Testing | <input type="checkbox"/> Reproductive 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)

- 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)

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 CREDENTIALS 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 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 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: _____