



500 Virginia Street, East
Suite 1200
Charleston, WV 25301

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 <u>During The Last 12 Months</u>	Indicate The Number Of Surgical Procedures You Expect To Perform At Your Facility <u>During The Next 12 Months</u>
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:

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

- 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, please 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: _____