



Medical Imaging Centers, Medical Laboratories Mainform Application

Applicant Information

1. Applicant name:

2. Principal business address (attach separate sheet if more than one location):

3. Telephone number:

4. Date established:

5. Applicant's practice is a:

<input type="checkbox"/> Solo practitioner (unincorporated)	<input type="checkbox"/> Solo practitioner (incorporated)
<input type="checkbox"/> Corporation (for-profit)	<input type="checkbox"/> Corporation (non-profit)
<input type="checkbox"/> Professional Association	
<input type="checkbox"/> Other (please describe):	

6. Please provide a detailed description of operations:

7. Please state sources and amounts of total revenue:

	in last 12 months	for next 12 months
Charitable contributions	\$	\$
Government funding	\$	\$
Fee for services	\$	\$
Other – specify:	\$	\$

Operations and Activities

8. The applicant facility is: Mobile Stationary

9. a. Is the applicant accredited? Yes No

b. Please list specialty service or organizational certifications:

10. Provide the percentages of services provided for:

Hospitals	%	Nursing Homes	%	Industrial Facilities	%
Vet Clinics	%	Physician Offices	%		
Other – please describe:					%

11. Please indicate the number of tests:

Type of Test	in last 12 months	for next 12 months
Bone density scans		
CAT/CT scans		
EKG/EEG		
Mammograms		



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MRI		
PET scans		
Ultrasound/sonography		
X-ray		
Urine/blood		

12. Is the applicant involved in:
- a. the use of contract media injections and localization markers? Yes No
 - b. the use of any radioactive material other than used in x-ray equipment? Yes No
 - c. therapy or treatment procedures? Yes No
 - d. environmental analysis? Yes No
 - e. blood banking or cross matching? Yes No
 - f. drug testing or research? Yes No
 - g. testing for AIDS? Yes No
 - h. manufacturing, dispensing, or testing pharmaceuticals? Yes No
 - i. manufacture and/or sell laboratory equipment or supplies, reagents, or software? Yes No
 - j. intravenous transfusions of blood or in the procurement of blood or blood products? Yes No

If Yes to any of the above, please provide a full description:

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13. Is anesthesia (other than topical or by means of local infiltration) administered by either applicant or others? Yes No
- If Yes, please explain in the comments section.

14. a. Provide percentage of specimens:
- i. collected direct from patients by the applicant

%

 - ii. received by the applicant from outside sources

%

- b. Describe types of specimens collected:

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Staffing Information

- 15 a. Please indicate the number of employed and contracted staff:

Profession	Employed	Contracted
Nurses		
Phlebotomists		
Physicians		
X-ray technicians		
Other – specify:		



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- i. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes No
If No, please explain in the comments section.
- ii. Do you require all employed/contracted radiologist physicians to carry their own medical liability insurance? Yes No
- iii. Do you maintain Certificates of Insurance to confirm such coverage? Yes No
- b. Has the applicant or have any of the above employees:
 - i. ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association? Yes No
 - ii. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No
 - iii. ever been treated for alcoholism or drug addiction? Yes No
 - iv. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? Yes NoIf Yes to any of the above, please explain in the comments section.

16. Provide the name of the applicant's Medical Director and attach a copy of his/her Curriculum Vitae (CV).

Risk Management Procedures

- 17. Is there a quality assurance/safety program that includes calibrating equipment, identifying irregularities, and utilizing controls? Yes No
 - 18. Is there complete documentation of proper use and maintenance of equipment? Yes No
 - 19. Are there policies/procedures in place for the use, administration, and proper disposal of radio-pharmaceuticals? Yes No
 - 20. Is informed consent for special procedures including injection of contrast or other media obtained? Yes No
 - 21. Is there a written policy for handling allergic reactions including cardiac or respiratory arrests? Yes No
- If No to any of the above, please explain in the comments section.

Insurance and Claims History

- 22. Has any similar insurance ever been declined or cancelled? Yes No
If Yes, please explain in the comments section.
- 23. Does any person to be insured have knowledge or information of any act, error, or omission which might reasonably be expected to give rise to a claim against him/her? Yes No
If Yes, please attach complete details including a description of the incident(s).
- 24. After inquiry have any claims been made against any proposed Insured(s) during the past five (5) years? Yes No
If Yes, please complete a supplemental claims information form for each claim.



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25. How many claims have been made in the last five (5) years?

26. a. List prior professional liability insurers for the past five years (if none, please tick box)

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim / aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

27. a. Is the applicant currently insured under a commercial general liability policy including products and completed operations coverage? Yes No

Insurer	Dates covered from-to (mm/dd/yy)	Limits of liability per claim / aggregate	Deductible	Premium	Coverage type: occurrence or claims-made
		/			
		/			
		/			
		/			
		/			

b. If the current/expiring policy is on a claims-made form, what is the retroactive date?

Comments Section



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It is understood and agreed that with respect to questions 23 and 24, that if such knowledge or information exists any claim or action arising there from is excluded from this proposed coverage.

Notice to New York applicants: any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material thereto, commits a fraudulent insurance act, which is a crime.

The applicant hereby acknowledges that he/she/it is aware that the limit of liability shall be reduced, and may be completely exhausted, by the costs of legal defense and, in such event, the Insurer shall not be liable for the costs of legal defense or for the amount of any judgment or settlement to the extent that such exceeds the limit of liability.

The applicant further acknowledges that he/she/it is aware that legal defense costs that are incurred shall be applied against the deductible amount.

I DECLARE that, after inquiry, the above statements and particulars are true and I have not suppressed or misstated any material fact and that I agree that this application shall be the basis of the contract with the Underwriters.

Name of applicant:

Signature of person authorized to execute on behalf of the applicant:

Name/title of person authorized to execute on behalf of the applicant:

Date:

This application form duly completed, together with any supplementary information, must be signed in ink or by electronic signature by the person indicated.

Signing of this form does not bind the applicant or the Underwriters to complete this insurance.

A copy of this application should be retained for your records.