AMBULATORY SURGERY CENTER
LOCATION APPLICATION

This is a supplemental application. Please complete a separate application for each facility. If a question does not apply to the facility, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. Your signature is required on page 17.

In addition to the completed application, please provide the following items:

- A copy of the facility's letterhead(s) and advertisements
- A list of all procedures permitted to be performed in the facility
- **A roster of the individuals who provide services in or on behalf of the facility (refer to Section III for specifics)**

SECTION I IDENTIFYING INFORMATION

Name of Facility				
Address	City	County	State	Zip Code
Telephone Number	Fax Number	Website Address		
Location Type:	☐ Freestanding – Hospital Satellite ☐ Freestanding – Independent ☐ Hospital-based ☐ Office-based Suite ☐ Other (specify): _____			
Specialty(ies):	☐ General Surgery ☐ Gynecology ☐ Ophthalmology ☐ Orthopedic Surgery ☐ Plastic Surgery ☐ Other (specify): _____			

Hours of Operation:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

1. Please describe the ownership of the facility. If there is more than one owner, attach an organizational chart that identifies the facility's ownership structure and each owner's percentage of ownership interest:

   _____

   _____

2. Are the services provided in the facility limited to a specific physician or medical group? ☐ **Yes** ☐ **No**

   If yes, please identify the physician or medical group:

   _____

   _____

SECTION II COVERAGE/INSURANCE INFORMATION

Professional Liability Insurance History

NOTE: Please complete the questions in this section only if the facility's insurance history is different from the organization's professional liability insurance history as indicated on the Health Care Facilities Policy Application

1. Please complete the following regarding all professional liability insurance maintained by the facility during the past ten years, beginning with the most recent. Please photocopy this page if additional space is needed.

Name of Insurer	Coverage Dates (From/To)	Deductible or Self Insured Retention	Policy Type	If Claims Made, Check One
	From ______ To ______	Deductible: ____, SIR: ____ Amount: ____________	Claims Made ___ Occurrence: ___	Tail Coverage Purchased: ___ Prior Acts Purchased From Subsequent Carrier? ___
Name of Insurer	**Coverage Dates (From/To)**	**Deductible or Self Insured Retention**	**Policy Type**	**If Claims Made, Check One**
	From ______ To ______	Deductible: ____, SIR: ____ Amount: ____________	Claims Made ___ Occurrence: ___	Tail Coverage Purchased: ___ Prior Acts Purchased From Subsequent Carriers? ___
Name of Insurer	**Coverage Dates (From/To)**	**Deductible or Self Insured Retention**	**Policy Type**	**If Claims Made, Check One**
	From ______ To ______	Deductible: ____, SIR: ____ Amount: ____________	Claims Made ___ Occurrence: ___	Tail Coverage Purchased: ___ Prior Acts Purchased From Subsequent Carriers? ___
Name of Insurer	**Coverage Dates (From/To)**	**Deductible or Self Insured Retention**	**Policy Type**	**If Claims Made, Check One**
	From ______ To ______	Deductible: ____, SIR: ____ Amount: ____________	Claims Made ___ Occurrence: ___	Tail Coverage Purchased: ___ Prior Acts Purchased From Subsequent Carriers? ___
Name of Insurer	**Coverage Dates (From/To)**	**Deductible or Self Insured Retention**	**Policy Type**	**If Claims Made, Check One**
	From ______ To ______	Deductible: ____, SIR: ____ Amount: ____________	Claims Made ___ Occurrence: ___	Tail Coverage Purchased: ___ Prior Acts Purchased From Subsequent Carriers? ___

SECTION III HEALTH CARE PROVIDERS

1. Please provide the name and designation of the medical director:

   _____

   _____

2. Please provide a roster of all individuals who provide services in or on behalf of the facility. The roster must include the following items for each individual:

   - Name and designation
   - Type of provider (i.e., physician, nurse practitioner, registered nurse, etc.)
   - Medical specialty if a physician
   - Whether the individual is a partner/shareholder, employee, independent contractor or staff member
   - Name of professional liability insurance company if a physician

3. Does the facility lease any health care personnel from other organizations or individuals (e.g., temporary employment agencies)? ☐ **Yes** ☐ **No**

   If yes, please provide a copy of the contract(s).

4. Are all personnel who provide professional health care services in or on behalf of the facility licensed and/or certified as required by state law for the services they provide? ☐ **Yes** ☐ **No**

   If no, please explain:

   _____

   _____

5. Please answer the following regarding those individuals who render services in or on behalf of the facility but who are **not** employees:

   a. Are they required to maintain professional liability insurance with limits of liability of at least $1 million per claim/$3 million annual aggregate? ☐ **Yes** ☐ **No**

   b. Are they required to provide proof of professional liability insurance at least annually? ☐ **Yes** ☐ **No**

   If you answered no to question 5a or 5b, please explain:

   _____

   _____

6. Please check all that apply to individuals who are rendering services in or on behalf of the facility but who are not owners or employees:

Share in the facility's profits and/or overhead expenses?	☐ **Yes** ☐ **No**
Use the facility's letterhead?	☐ **Yes** ☐ **No**
Use the facility's advertisements?	☐ **Yes** ☐ **No**
Bill under the facility's name?	☐ **Yes** ☐ **No**

   If you answered yes to any one of the above, please identify the name and designation of each individual and the applicable common action(s) pertinent to him or her:

   _____

   _____

SECTION IV ACCREDITATION, CERTIFICATION AND LICENSURE

1. Has the facility ever been denied accreditation, certification and/or licensure, has its accreditation, certification and/or licensure ever been suspended or revoked or has it been subject to probationary terms or conditions? ☐ **Yes** ☐ **No**

   If yes, please explain and provide a copy of the results of the inspection(s) that led to the denial, suspension or revocation:

   _____

   _____

2. Please provide copies of the facility's state license(s) and Medicare ambulatory surgery center certificate.

   If the facility is not licensed and/or certified, please explain:

   _____

   _____

3. Is the facility currently accredited? ☐ **Yes** ☐ **No**

   If yes, please identify each agency and provide proof of accreditation, a copy of the agency's most recent inspection report and the facility's responses to any contingencies and/or deficiencies:

   ☐ JCAHO ☐ AAAASF ☐ AAAHC ☐ IMQ ☐ Other: _____

   If no, please indicate the following below:

   - Whether the facility is scheduled for an inspection, and if so, specify with which agency and the date of the inspection
   - The agency (governmental or nongovernmental) that last performed an on-site inspection at the facility and the date it performed the inspection:

     _____

     _____

SECTION V PROCEDURES AND SURGERIES

1. How many operating/procedure rooms does the facility have? _____

2. Please complete the following table regarding the *estimated* number of procedures and surgeries to be performed in the facility during the current year and the *actual* number of procedures and surgeries that were performed in the facility during the applicable prior years. Please provide the numbers for each calendar year (January through December).

Current Year Estimate	First Prior Year	Second Prior Year	Third Prior Year	Fourth Prior Year	Fifth Prior Year

3. Please provide the estimated percentage of procedures and surgeries that will be performed in the facility this year using the following types of anesthesia. Please use the American Society of Anesthesiologists' current definitions for the levels of sedation/analgesia:

Local/ Topical Anesthesia	Regional Anesthesia (excluding spinal/epidural)	Spinal/Epidural	Moderate Sedation	Deep Sedation	General Anesthesia
%	%	%	%	%	%

4. Please identify what percentage of the patients treated in the facility are classified in each of the following American Society of Anesthesiologists physical status classifications:

   Class I:_____% Class II:_____% Class III:_____% Class IV:_____% Class V:_____%

   If you indicated that Class III and above patients are treated in the facility, please identify the procedures performed and the types of anesthesia used on these individuals (attach additional pages as necessary):

   _____

   _____

5. Does the facility have a credentials committee/governing body that approves the permissible procedures for each medical specialty? ☐ **Yes** ☐ **No**

   If yes, are the procedures/surgeries that are performed in the facility limited to those that have been approved by the credentials committee/governing body? ☐ **Yes** ☐ **No**

   If you answered no to either question, please explain:

   _____

   _____

6. Are all individuals who perform procedures/surgeries in the facility required to maintain and provide proof of hospital privileges for the procedures/surgeries they intend to perform in the facility? ☐ **Yes** ☐ **No**

   If no, please explain and identify the credentialing process used to ensure that these individuals are qualified to perform the applicable procedures/surgeries:

   _____

   _____

7. Are individuals other than MDs or DOs permitted to perform procedures/surgeries in the facility? ☐ **Yes** ☐ **No**

   If yes, please identify the names and designations of these individuals and the procedures/surgeries permitted to be performed by them:

   _____

   _____

8. Are any one of the following performed in the facility?

   Bariatric Surgery ☐ **Yes** ☐ **No** Deliveries ☐ **Yes** ☐ **No**
   Cosmetic Surgery ☐ **Yes** ☐ **No** Liposuction ☐ **Yes** ☐ **No**

9. If you indicated that cosmetic surgery is performed in the facility, is any individual other than a plastic surgeon permitted to perform it? ☐ **Yes** ☐ **No**

If yes, please identify the name, designation and medical specialty of each individual and the cosmetic surgery permitted to be performed by him or her in the facility:

_____

_____

10. If you indicated that liposuction is performed in the facility, please complete the following:

a. Are 5000 ml or more of total aspirate extracted? ☐ **Yes** ☐ **No**

If yes, please identify the maximum amount that is extracted during a single procedure and indicate whether additional procedures are permitted to be performed when 5000 ml or more are extracted. If additional procedures are performed, please identify the procedures:

_____

_____

b. Is it performed under general anesthesia or intravenous sedation? ☐ **Yes** ☐ **No**

c. Is IV access *available* for procedures of less than 2000 ml total aspirate? ☐ **Yes** ☐ **No**

d. Is an IV *placed* for procedures of 2000 ml or more total aspirate? ☐ **Yes** ☐ **No**

e. Please indicate which of the following monitoring systems are available for volumes greater than 150 ml and less than 2000 ml of total aspirate (please check all that apply):

☐ Pulse oximeter
☐ EKG monitoring
☐ Blood pressure monitoring
☐ Fluid loss and replacement monitoring and recording

f. Are the monitoring systems listed under 10e always used for volumes of 2000 ml or more? ☐ **Yes** ☐ **No**

If you answered no to question 10c, 10d or 10f, or did not check every one of the items in 10e, please explain:

_____

_____

11. Please indicate which of the following is performed for each patient before the procedure/surgery and before the patient has received sedation (please check all that apply):

☐ History and physical examination
☐ Assessment of cardiopulmonary status
☐ Review of current medications and drug allergies
☐ Obtain informed consent

a. If you indicated that informed consent is obtained, is a written consent form always used to document that consent has been given? ☐ **Yes** ☐ **No**

If no, please identify how the patient's consent is documented:

_____

_____

b. Does any individual other than the anesthesiologist or the physician or surgeon performing the procedure perform any one of the items listed under question number 11 in lieu of the anesthesiologist or physician? ☐ **Yes** ☐ **No**

If yes, please identify the name and designation of the individual responsible, the item(s) performed by him or her and his or her qualifications:

_____

_____

12. Are all patients discharged home within 23 hours of their procedures/surgeries? ☐ **Yes** ☐ **No**

If no, please explain:

_____

_____

SECTION VI ANESTHESIA SERVICES

1. Please indicate what professional discipline (or specialty) of provider is credentialed and privileged to administer the following types of anesthesia in the facility. Please use the American Society of Anesthesiologists' current definitions for the levels of sedation/analgesia:

	Anesthesiologist	CRNA	Physician/ Surgeon	Dentist	Registered Nurse	Other: _____
Spinal/Epidural	☐	☐	☐	☐	☐	☐
IV Block	☐	☐	☐	☐	☐	☐
Major Nerve Block (i.e., brachial plexus, femoral nerve, etc.)	☐	☐	☐	☐	☐	☐
Moderate Sedation	☐	☐	☐	☐	☐	☐
Deep Sedation	☐	☐	☐	☐	☐	☐
General Anesthesia	☐	☐	☐	☐	☐	☐

2. Are all individuals who provide anesthesia in the facility required to maintain and provide proof of hospital privileges for the type(s) of anesthesia they intend to administer in the facility? ☐ **Yes** ☐ **No**

3. Is there an educational/credentialing mechanism in place that periodically evaluates and documents the competency of the individuals providing anesthesia in safely administering the medication, recognizing and treating any complications that may arise, and recognizing emergency situations and instituting emergency procedures? ☐ **Yes** ☐ **No**

4. Does the facility maintain pharmacological antagonists for the opiates and benzodiazepines administered, and is the person responsible for administering the anesthesia adequately familiar with their roles? ☐ **Yes** ☐ **No**

If you answered no to question 2, 3 or 4, please explain:

_____

_____

5. Is intravenous propofol administered in the facility? ☐ **Yes** ☐ **No**

   If yes, is anyone other than an anesthesiologist or CRNA administering the intravenous propofol? ☐ **Yes** ☐ **No**

   If yes, please identify each individual, his or her designation, the type of training that he or she has received and the qualifications of the individual(s) who provided the training:

   _____

   _____

6. Please indicate if the following types of patients are treated in the facility with the use of moderate sedation, deep sedation, spinal/epidural anesthesia or general anesthesia:

   Pediatric: ☐ **Yes** ☐ **No** Neonatal: ☐ **Yes** ☐ **No**

   If you marked yes for either or both of the above, please complete the following:

   a. Please identify the youngest age to be treated with general anesthesia: _____

   b. Is the facility equipped with age-appropriate surgical and monitoring equipment? ☐ **Yes** ☐ **No**

   c. If you indicated that pediatric patients are treated in the facility, is a Pediatric Advanced Life Support (PALS) certified provider immediately available during the perioperative and postoperative periods? ☐ **Yes** ☐ **No**

   d. If you indicated that neonatal patients are treated in the facility, is a Neonatal Advanced Life Support (NALS) certified provider immediately available during the perioperative and postoperative periods? ☐ **Yes** ☐ **No**

   If you answered no to question 6b, 6c or 6d, please explain:

   _____

   _____

SECTION VII PATIENT MONITORING, RECOVERY AND DISCHARGE

NOTE: Please answer the questions in this section only if patients are administered moderate sedation, deep sedation, spinal/epidural anesthesia or general anesthesia in the facility and answer them only as they relate to these patients.

1. Does intraoperative physiological monitoring include *continuous* use of blood pressure monitoring, EKG monitoring and oxygen saturation monitoring with pulse oximetry? ☐ **Yes** ☐ **No**

2. Is there a person dedicated to the *continuous* monitoring of the patient's vital signs and controlling the patient's level of consciousness during the procedure? ☐ **Yes** ☐ **No**

3. If general anesthesia is administered, is end-tidal CO_2 measured continuously and is there a means of measuring body temperature? ☐ **Yes** ☐ **No**

4. Does a provider certified in advanced resuscitative techniques (for example, Advanced Cardiac Life Support) always accompany patients throughout their perioperative and postoperative stay in the facility until the patient has been discharged home? ☐ **Yes** ☐ **No**

5. Who is responsible for monitoring patients during recovery?

   ☐ Physician ☐ Certified Registered Nurse Anesthetist ☐ LVN/LPN
   ☐ Medical Assistant ☐ Registered Nurse ☐ Other (please specify): _____

   Are patients *continuously* monitored by one of the above individuals in the recovery area? ☐ **Yes** ☐ **No**

6. Is a separate pulse oximeter available for each patient in the recovery area? ☐ **Yes** ☐ **No**

7. Is a licensed physician always on-site or immediately available by telephone until the patient has been discharged? ☐ **Yes** ☐ **No**

8. Is a patient's discharge always the responsibility of a licensed physician? ☐ **Yes** ☐ **No**

9. Are all patients provided written discharge orders? ☐ **Yes** ☐ **No**

10. Are all patients discharged with a responsible adult? ☐ **Yes** ☐ **No**

11. Do all patients receive a postoperative follow-up call from facility personnel within 24 hours of being discharged? ☐ **Yes** ☐ **No**

If you answered no to any one of questions 1 – 11, please explain:

_____

_____

_____

SECTION VIII ANCILLARY SERVICES

1. Does the facility provide any of the following services on-site?

   Pharmaceutical ☐ **Yes** ☐ **No** Laboratory ☐ **Yes** ☐ **No** Radiology ☐ **Yes** ☐ **No**

   If yes, please answer the remaining questions in this section.

2. Does the facility maintain separate professional liability insurance for any one of these services? ☐ **Yes** ☐ **No**

   If yes, please identify the service(s) for which the separate professional liability insurance is maintained and provide proof of the insurance:

   _____

   _____

3. Are the services provided only for individuals who will undergo surgery or a procedure in the facility? ☐ **Yes** ☐ **No**

   If no, please explain:

   _____

   _____

4. If laboratory services are provided on-site, please answer or provide the following:

   a. Please identify which one of the following currently applies regarding the facility's CLIA certification:

      ☐ Certificate of Compliance ☐ Certificate of Accreditation ☐ Certificate of Waiver
      ☐ Certificate for Provider-Performed Microscopy Procedures ☐ Certificate of Registration
      ☐ No Certificate (please explain): _____

   b. If the facility has a certificate of registration, when is the facility scheduled to be inspected? _____

   c. Please provide a copy of the facility's laboratory license.

   d. Are the laboratory services provided by the facility limited to those authorized by its CLIA certification? ☐ **Yes** ☐ **No**

      If no, please explain:

      _____

      _____

5. If radiology services are provided on-site, does any one other than a radiologist interpret the images? ☐ **Yes** ☐ **No**

   If yes, please indicate who interprets the images, the type(s) of images interpreted by nonradiologists and whether the images are overread by a radiologist:

   _____

   _____

   If a radiologist does not overread the images interpreted by a nonradiologist, does the individual who interpreted the image render a formal report? ☐ **Yes** ☐ **No**

   If no, please explain:

   _____

   _____

SECTION IX TELEMEDICINE

Telemedicine is defined as "the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video or data communications. Neither a telephone conversation nor an electronic mail message between a licensed health care practitioner and another licensed health care practitioner and/or between a licensed health care practitioner and a patient constitute telemedicine."

1. Does the facility:

   a. Provide telemedicine services? ☐ **Yes** ☐ **No**

   b. Receive telemedicine services? ☐ **Yes** ☐ **No**

   If you answered yes to either of the above, please explain and provide a copy of the contract(s):

   _____

   _____

SECTION X MISCELLANEOUS

1. Does the facility maintain a transfer agreement with any general acute care hospital(s)? ☐ **Yes** ☐ **No**

   If yes, please identify each hospital and the facility's distance to it (in miles):

   _____

   _____

   If no, please explain:

   _____

   _____

2. Does the facility maintain a crash cart that is immediately available to each patient in the facility at all times and that is equipped with at least cardiac drugs (needed to comply with current ACLS standards), basic airway and IV access equipment, a cardiac monitor/defibrillator *and* supplemental oxygen? ☐ **Yes** ☐ **No**

   If no, please identify the emergency equipment that is available in the facility:

   _____

   _____

3. Are any drugs, pharmaceuticals, devices or equipment used, administered, distributed or prescribed in or on behalf of the facility that are disapproved or not yet approved by the United States Food and Drug Administration (FDA) for treatment of human beings? ☐ **Yes** ☐ **No**

   If yes, please explain:

   _____

   _____

4. Are all medications stored in a secure location and handled in compliance with federal, state and local laws and regulations? ☐ **Yes** ☐ **No**

5. Is there an emergency power source available? ☐ **Yes** ☐ **No**

6. Does the facility comply with all federal, state and local laws and regulations regarding the disposal of hazardous waste material? ☐ **Yes** ☐ **No**

7. Is all facility equipment (i.e., anesthesia, emergency, etc.) maintained, tested and inspected according to manufacturers' guidelines and federal, state and local laws and regulations? ☐ **Yes** ☐ **No**

If you answered no to any one of questions 4 – 7, please explain:

_____

_____

8. Is the facility involved in any teaching program or is it utilized to train individuals other than its employees? ☐ **Yes** ☐ **No**

   If yes, please describe the program, identify who provides the training, who is trained, what type of training is provided and how often this occurs, and attach any applicable information regarding the program:

   _____

   _____

9. Does the facility treat individuals requiring emergency care? ☐ **Yes** ☐ **No**

   If yes, please explain what emergency services are provided, under what circumstances they are provided and how often they are provided:

   _____

   _____

10. Are services of the facility provided under any contractual agreement(s) (excluding those with managed care organizations)? ☐ **Yes** ☐ **No**

    If yes, please identify the organization(s) and person(s) with which it contracts and provide a copy of the contract(s):

    _____

    _____

11. Are there any changes planned for the facility (for example, new specialties or new procedures)? ☐ **Yes** ☐ **No**

    If yes, please identify the changes and the anticipated date on which the changes will be made:

    _____

    _____

SECTION XI RISK MANAGEMENT

1. Does the facility have a formal risk management program? ☐ **Yes** ☐ **No**

   a. **If yes,** who (name and title) is responsible for the risk management program?

   _____

   b. **If no,** please explain:

   _____

   _____

Credentialing

1. Does the facility have a formal process to credential its health care providers? ☐ **Yes** ☐ **No**

   a. **If yes,** please identify who performs the initial credentialing (e.g., employee, hospital, outside company):

   _____

   _____

   b. **If no,** please explain:

   _____

   _____

2. Does the facility evaluate the following when credentialing its health care providers?

Claim History	☐ **Yes**	☐ **No**	**If yes,** source(s) used: _____
Hospital Privileges	☐ **Yes**	☐ **No**	
Employment History	☐ **Yes**	☐ **No**	**If yes,** source(s) used: _____
Education History	☐ **Yes**	☐ **No**	**If yes,** source(s) used: _____
Felony/Misdemeanor History	☐ **Yes**	☐ **No**	**If yes,** source(s) used: _____
Medical/Dental/Nursing and Narcotic Licenses	☐ **Yes**	☐ **No**	**If yes,** source(s) used: _____

   If you answered no to any one of the above, please explain:

   _____

   _____

3. Does the facility use the same credentialing procedures to credential independent contractors and locum tenens health care providers? ☐ **Yes** ☐ **No**

   If no, please describe the credentialing process used:

   _____

   _____

4. How often are the facility's health care providers recredentialed?

   _____

   _____

Quality Assurance

1. Does the facility maintain written policies for the handling of emergency situations and are all health care personnel trained on them? ☐ **Yes** ☐ **No**

   If yes:

   a. Are new employees required to complete this training before being allowed patient contact? ☐ **Yes** ☐ **No**

   b. How often is training updated? _____

   If you answered no to question 1 or 1a, please explain:

   _____

   _____

2. Does the facility have a formal process to evaluate and address concerns of unexpected patient outcomes? ☐ **Yes** ☐ **No**
3. Does the facility have a formal process to evaluate patient complaints? ☐ **Yes** ☐ **No**
4. Does the facility conduct patient satisfaction surveys? ☐ **Yes** ☐ **No**

   If yes, how often: _____

Utilization Review

1. Does the facility have its own utilization review committee? ☐ **Yes** ☐ **No**

   If yes:

   a.. Does the facility have written policies and procedures for appeals of denied procedures? ☐ **Yes** ☐ **No**

   b. Who performs the utilization reviews? _____

   _____

   c. Are claim denial procedures explained in writing to patients? ☐ **Yes** ☐ **No**

   d. Does a physician review all proposed denials of benefits? ☐ **Yes** ☐ **No**

   e. Is there a fast track appeal system for denied procedures that may severely impair the quality of life for a patient if not performed? ☐ **Yes** ☐ **No**

Medical Records

1. Does the facility currently use electronic medical records? ☐ **Yes** ☐ **No**

   If yes:

   a. Who is the vendor? _____

   b. How often are the electronic files backed up? _____

   c. Who backs up the files? _____

   d. Are the backed-up files stored at an off-site location? ☐ **Yes** ☐ **No**

   If you answered no to question 1d, please explain:

   _____

   _____

   e. Are all systems (e.g., inpatient, outpatient, billing, scheduling) electronic? ☐ **Yes** ☐ **No**

   If you answered no to question 1e, how are the different systems coordinated?

   _____

   _____

2. Do the facility's health care providers create and maintain a medical record for each patient under their care? ☐ **Yes** ☐ **No**
3. Is it a requirement that operative/procedure notes be dictated/written on the day of the procedure? ☐ **Yes** ☐ **No**

If you answered no to question 2 or 3, please explain:

_____

_____

4. How are record-keeping deficiencies identified and handled?

   _____

   _____

SECTION XII SUPPLEMENTAL QUESTIONS

If you answer YES to any one of the following questions, you must provide a detailed, written narrative (including, but not limited to, date of occurrence, reason for occurrence and the resolution) and pertinent documentation (e.g., medical board documents, letters from a hospital, diversion program and/or treating physician, etc.).

1. Has any governmental agency **ever** investigated, placed on probation, suspended or taken any action against the facility? ☐ **Yes** ☐ **No**
2. Have the facility's membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, subject to probationary terms or conditions, or otherwise investigated or limited in any way, for possible incompetence, improper professional conduct or breach of conduct, or is any such action pending? ☐ **Yes** ☐ **No**
3. Has the facility **ever** surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? ☐ **Yes** ☐ **No**
4. Has the facility or any facility member **ever** been accused of sexual misconduct? ☐ **Yes** ☐ **No**
5. Do you know if any individual who works on the facility's behalf has a prior history or propensity for sexual misconduct? ☐ **Yes** ☐ **No**

SECTION XIII CLAIMS HISTORY

Other than any claims, incidents, etc. that have already been reported on the organization's main application, if applicable:

1. Within the past ten (10) years, has a malpractice claim or suit been brought against the facility, or has the facility been notified of its involvement in a malpractice claim or suit, either directly or indirectly? ☐ **Yes** ☐ **No**
2. Is the facility aware of any medical incident or accident, conduct, circumstance or occurrence that might reasonably be expected to give rise to a claim or suit against the facility, directly or indirectly, even if you believe the claim or suit would be without merit? ☐ **Yes** ☐ **No**

If you answered yes to question 1 or 2, please complete a Claim Information Form on page 16 for each applicable claim, suit, incident, conduct, etc.

SECTION XIV PRIOR ACTS COVERAGE

NOTE: If the facility is not applying for Prior Acts Coverage, please skip this section.

Please ensure that your answers to the following questions reflect the facility's practice as it was during the Prior Acts Period.

1. Since the Requested Retroactive Date, has there been a change in the legal structure of the facility (for example, change in owners, type of entity)? ☐ **Yes** ☐ **No**

   If yes, please explain and identify the appropriate dates:

2. Since the Requested Retroactive Date, have there been any material changes in the facility's practice (for example, types of procedures performed or services provided)? ☐ **Yes** ☐ **No**

   If yes, please explain and identify the appropriate dates:

REMARKS

Beneath "Question Number," please indicate the question number and, if applicable, the letter (e.g., 2, 3b). Please photocopy this page if additional space is needed.

Page Number	Section Number	Question Number	Remarks

Please provide any additional information material to the risk that has not otherwise been addressed in this application:

CLAIM INFORMATION FORM

Name of Patient: _____ Gender: ☐ Male ☐ Female

Age of Patient (at time of treatment): _____

Name of Claimant (if different than patient): _____

Location of Incident: _____

Allegation Against the Facility: _____

_____

Facility Member Defendants: _____

_____

Non-Facility Member Defendants: _____

_____

Date Incident or Claim Was Reported to the Insurance Company: _____

Name of Insurance Company: _____

Disposition or Current Status of the Incident, Claim or Suit Against the Facility:

☐ Open

- ☐ Incident has been reported but claim or suit has not been filed
- ☐ Claim or suit has been filed and is awaiting start of arbitration, mediation, trial, etc.
- ☐ Claim or suit is currently in arbitration or mediation or is being tried in court
- ☐ Settlement has been made or judgment returned but remains open

☐ Closed Date Closed (month/day/year): _____

- ☐ Incident was reported but claim or suit was not filed
- ☐ Claim or suit was filed but was dismissed or dropped before trial
- ☐ Claim or suit was filed but settlement was made
- ☐ Verdict or judgment was made in the entity's favor
- ☐ Verdict or judgment was made in favor of the plaintiff

Total loss payment amount (if payment made): _____

Amount paid on the facility's behalf: _____

Total verdict amount (if different than total loss payment amount): _____

CLAIM INFORMATION NARRATIVE

Please describe the care and treatment of the patient. Attach additional pages as needed. Your narrative must provide adequate clinical detail to allow proper evaluation by a committee of physicians and must include the following information:

- Condition and diagnosis at time of treatment
- Dates and a description of treatment rendered
- Condition of patient subsequent to treatment
- Copies of patient(s) chart(s) and operative report(s) as appropriate

I understand the information submitted herein becomes part of my facility's insurance application as submitted.

Signature of Authorized Representative

Date

Name (Print)

When completed, please fax to (818) 343-4075 or e-mail to info@securenetinsurance.com