



# HEALTHCARE FACILITY RENEWAL QUESTIONNAIRE

## Required Documents

In addition to this questionnaire, the following information is **required**:

1. Currently valued prior carrier Loss Runs covering the past ten (10) years if the Policyholder has been insured with us for less than ten (10) years
2. If Excess Liability coverage is provided:
  - Currently valued Loss Runs covering the past ten (10) years for all underlying coverages not insured by us
  - Declarations page for each underlying policy
3. Roster of all employed and contracted physicians, residents, interns, externs, podiatrists, chiropractors and dentists insured with a different carrier or under a separate Curi policy. Refer to section D3 for a list of information needed.
4. Listing of Locations (or Statement of Values) with description of use
5. Audited Consolidated Financial Statements for the past two (2) years
6. Organizational Ownership Chart reflecting all legal entities and DBAs
7. Roles and Responsibilities for volunteer workers as applicable

A. POLICYHOLDER INFORMATION		
Policyholder:	Policy Number:	
To update current contact information, please provide the new contact information below or select "No Change".		
Mailing c/o or Attn, if applicable:	<input type="checkbox"/> No Change	
Mailing Address:		
Billing Address:		
Risk Manager:	Phone:	Email:

B. OPERATIONAL CHANGES	
<p>1. Considering the Policyholder's operations within the <b>past twelve (12) months</b>, select all that apply and include an explanation in the Comments section. If none of the following apply, please select 'No change'.</p> <p><input type="checkbox"/> Acquired any operations, entities, or subsidiaries</p> <p><input type="checkbox"/> Sold, discontinued, or divested any operations, entities or subsidiaries</p> <p><input type="checkbox"/> Entered into any joint venture or limited partnership arrangement</p> <p><input type="checkbox"/> Increased or decreased the number of employees by more than 20%</p> <p><input type="checkbox"/> Experienced any changes in management services provided to others</p> <p><input type="checkbox"/> Added, discontinued, or materially changed services offered</p> <p><input type="checkbox"/> Added or closed any locations</p> <p><input type="checkbox"/> Began operations in any new state(s)</p> <p><input type="checkbox"/> No changes</p>	
<p>2. Considering the <b>next twelve (12) months</b>, does the Policyholder anticipate any operational changes? If yes, please describe in the Comments section:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3. Considering the <b>next twelve (12) months</b>, does the Policyholder plan to start any construction or renovation projects on property owned by or leased from the Policyholder? If yes, answer the following:</p> <p>a. Provide a description of the project(s):</p> <p>b. Estimated total cost of the project(s): \$</p> <p>c. Estimated duration of the project(s):</p> <p>d. Will the Policyholder purchase General Liability coverage for this project? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></p> <p>If yes, select the type of insurance purchased:</p> <p><input type="checkbox"/> Builder's Risk with general liability coverage    <input type="checkbox"/> Owner-Controlled Insurance Program ("OCIP")</p> <p><input type="checkbox"/> Other liability policy (describe):</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**C. GENERAL OPERATIONS**

1. Provide a description of services offered:

2. List all states where the Policyholder provides services. If there is more than one state, provide the estimated percentage of work by state. *This list should include states where telemedicine is provided.*

3. What patient populations are served:

- Children (birth through age 12) \_\_\_\_\_%     
  Adults (ages 19 through 64) \_\_\_\_\_%  
 Adolescents (ages 13 through 18) \_\_\_\_\_%     
  Geriatrics (age 65 and older) \_\_\_\_\_%

4. Is overnight care provided?       Yes    No

5. Specify where services are provided below. Check all boxes that apply.

**Acute and Inpatient Facilities**

- Hospital  
 Nursing Homes/Extended Care Facility  
 Rehabilitation Center  
 Hospice  
 Mental Health/Substance Abuse Facility

**Outpatient and Ambulatory Settings**

- Physician / Provider Office  
 Ambulatory Surgical Center  
 Urgent Care Center  
 Retail Clinic  
 Mental Health/Substance Abuse Clinic  
 Dialysis Center  
 Laboratory  
 Pharmacy  
 Diagnostic Imaging Center  
 Free Standing Facility

**Home and Community Based Care**

- Community Health Center  
 Patient's Home  
 Day Care Center

6. Is the Policyholder managed by a management company? If yes, answer the following questions.       Yes    No

a. What is the name of the management company:

b. How long has the Policyholder been managed by this management company?

c. Who is the professional liability carrier for the management company:

d. Do you require proof of coverage?       Yes    No

e. Describe management services being provided:

7. In the past twelve (12) months, have you agreed to provide management services to other facilities? If yes, describe in the Comments section.       Yes    No

8. Specify gross revenue for the current year (12 months):      Projected 12 months:

9. List all owners, including owners that are not medical professionals. Attach a separate document if necessary.

Individual/Entity Owner Full Name	% of Ownership	Medical Specialty or Professional Occupation	Professional Liability Carrier	If medical professional, list % of practice for Policyholder.
				%
				%
				%
				%
				%

10. Has the Policyholder filed for bankruptcy in the past twelve (12) months? If yes, please give name of the legal entity and details of the arrangement:       Yes    No

11. Is the Policyholder involved in any research activities? If yes, describe in the Comments section.       Yes    No

## D. MEDICAL STAFF

1. Provide the total number of employees, including non-medical staff:
2. Specify the number of employed and contracted medical professionals working on behalf of the Policyholder.

Provider Type	Employed	Contracted	Provider Type	Employed	Contracted
Physicians (MDs & DOs)			Podiatrists		
Residents			Chiropractors		
Interns & Externs			Dentists		

3. Are any of the employed or contracted providers above insured with a different carrier or under a separate Curi policy?  Yes  No  
 If yes, please attach a roster and include the following information:
  - Full Name (First, Middle Initial, Last) and Designation
  - Date of Birth
  - Social Security Number
  - NPI Number
  - Medical Specialty
  - Surgical Category: No Surgical Procedures, Minor Surgical Procedures or Surgery
  - Prior Acts Date (if claims-made)
  - State Medical License Number(s)
  - Employment Status (employed or contracted)
  - Hours worked for any part-time providers
  - Specify if coverage is desired. If not, specify current carrier.

4. Using the chart below, specify all other medical professionals working on behalf of the Policyholder. Compute full-time equivalents (FTE) for all part-time providers by using 40 hours per week as one full-time equivalent.

Type	Employed FTE	Contracted FTE	Type	Employed FTE	Contracted FTE
Anesthesia Assistants			Pharmacists		
CRNA's			Psychologists		
Certified Nurse Midwives			Physician Assistants		
EMTs/Paramedics			RN/LPN/LVN		
Estheticians			Speech Therapists		
Heart/Lung Perfusionists			Social Workers		
Laboratory Technicians			Surgical Assistants		
Nurse Practitioners			X-Ray Technicians		
Occupational/Physical Therapists			Other:		
Optometrists			Other:		

**Considering all medical staff employed or contracted by the Policyholder, please answer the following questions. Please explain all "yes" answers in the Comments section.**

5. Has any medical staff's license been restricted, suspended, surrendered or revoked?  Yes  No
6. Has any medical staff been accused of sexual misconduct, including unfounded accusations?  Yes  No
7. Has any medical staff been hired who has a criminal record?  Yes  No
8. Has the Policyholder made a report to the National Practitioner Data Bank on any provider(s)?  Yes  No
9. Are there any medical staff or volunteers for whom you do not conduct both state and nationwide criminal background checks, including checks for sexual offenses?  Yes  No

## E. MEDICAL EQUIPMENT / PRODUCTS

1. Does the Policyholder sell, rent/lease or distribute medical equipment or products **to others**?  Yes  No  
 If yes, check the appropriate category and answer the following questions:  
 Durable Medical Equipment/Supplies  Expendable Medical Equipment/Supplies  Medical Products
2. Does the Policyholder provide service or maintenance for the equipment/products?  Yes  No
3. If an outside vendor provides maintenance, what limits of liability insurance are required? \$
4. Does the Policyholder repackage or redesign the equipment/products?  Yes  No
5. Describe the type of equipment/products below and include whether they are sold, rented, leased or distributed.

## F. PROFESSIONAL SERVICES

DIRECTIONS: Check each box that applies, giving the requested information for each classification using the most recent 12 months. Use the Comments section for additional classifications not listed or for further explanation.

Visits	Count the number of patients entering a facility regardless of the number of departments visited or procedures performed. Include visits made to a client's home when home healthcare is provided.
Annual Revenue	Use annual gross revenues resulting from services performed. The number must represent an annual figure based upon fiscal year, calendar year or policy period.
Beds	Use the average number of occupied beds by dividing the total annual inpatient days by 365.
FTE	Use the full-time equivalent based upon 2080 annual hours.
Donations	Rate for each unit received from a donor.

### Behavioral Health

	Visits	Beds
<input type="checkbox"/> Mental Health Counseling	_____	_____
<input type="checkbox"/> Substance Abuse Counseling	_____	_____
<input type="checkbox"/> Developmental Disability	_____	_____
<input type="checkbox"/> Crisis Center	_____	_____

### Rehabilitation

	Visits	Beds
<input type="checkbox"/> Cardiac Rehabilitation	_____	_____
<input type="checkbox"/> Physical or Occupational Rehab	_____	_____
<input type="checkbox"/> Trauma Rehabilitation Therapy	_____	_____
<input type="checkbox"/> Trauma Rehab/Transitional Living	_____	_____

### Surgical / Specialized Services

	Visits	Beds
<input type="checkbox"/> Birthing Center	_____	_____
<input type="checkbox"/> Endoscopy	_____	_____
<input type="checkbox"/> Lithotripsy	_____	_____
<input type="checkbox"/> Surgery Center	_____	_____
<input type="checkbox"/> X-Ray / Imaging	_____	Revenue

### Hospice / Home Healthcare

	Visits	Beds
<input type="checkbox"/> Hospice Care	_____	_____
<input type="checkbox"/> Intravenous Therapy	_____	_____
<input type="checkbox"/> Personal/Companion Care	_____	_____
<input type="checkbox"/> Rehabilitation Therapy	_____	_____
<input type="checkbox"/> Respiration Therapy	_____	_____
<input type="checkbox"/> Skilled Care	_____	_____
<input type="checkbox"/> Durable Medical Equipment	_____	Revenue
<input type="checkbox"/> Pharmacy	_____	Revenue

### Staffing Agency

Specify Provider Type and FTE Below

<input type="checkbox"/>	FTE
<input type="checkbox"/>	FTE
<input type="checkbox"/>	FTE
<input type="checkbox"/>	FTE

### Non-Direct Healthcare Services

<input type="checkbox"/> Dental Laboratory	_____	Revenue
<input type="checkbox"/> Medical Laboratory	_____	Revenue
<input type="checkbox"/> Ocular Laboratory	_____	Revenue
<input type="checkbox"/> Pathology Laboratory	_____	Revenue
<input type="checkbox"/> Pharmacy	_____	Revenue
<input type="checkbox"/> Durable Medical Equipment	_____	Revenue
<input type="checkbox"/> Blood/Plasma Bank	_____	Donations
<input type="checkbox"/> Organ Bank-direct processing	_____	Donations
<input type="checkbox"/> Organ Bank-no direct processing	_____	Donations

### Treatment Centers

<input type="checkbox"/> College/University Health Center	Visits
<input type="checkbox"/> Community Health Center	Visits
<input type="checkbox"/> Convenience Care/Retail Clinic	Visits
<input type="checkbox"/> Dialysis Center	Visits
<input type="checkbox"/> Medi Spa	Visits
<input type="checkbox"/> Municipal Health Department	Visits
<input type="checkbox"/> Oncology Services	Visits
<input type="checkbox"/> Optical Establishment	Revenue
<input type="checkbox"/> Sleep Lab	Beds
<input type="checkbox"/> Sleep Lab	Visits
<input type="checkbox"/> Urgent Care Center	Visits
<input type="checkbox"/> Weight Loss Center	Visits
<input type="checkbox"/> Family Practice Clinic	Visits

### Ambulance Companies

<input type="checkbox"/> Emergency Medical Technician	FTE
<input type="checkbox"/> Paramedic	FTE
<input type="checkbox"/> Other provider type:	FTE

### Other

<input type="checkbox"/> Child Day Care	Enrollees
<input type="checkbox"/> Adult Day Care	Enrollees
<input type="checkbox"/> Fitness Center (open to public)	Revenue

G. SURGICAL PROCEDURES	
<b>Anesthesia</b>	
1. Is anesthesia provided? If yes, answer the following questions. If no, proceed to question 5.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. What level of anesthesia is provided?	
<input type="checkbox"/> Level A	Local or topical anesthesia
<input type="checkbox"/> Level B	Local or topical anesthesia and/or IV or parenteral sedation, regional anesthesia, analgesia or dissociative drugs without the use of endotracheal or laryngeal mask intubation or inhalation general anesthesia (including nitrous oxide)
<input type="checkbox"/> Level C	Levels listed above and/or surgical procedures with epidural anesthesia, endotracheal or laryngeal mask intubation or inhalation anesthesia, spinal or epidural
3. Is a physician, CRNA or RN with Advanced Cardiac Life Support certification immediately available on the premises until all patients have met documented discharge criteria?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is Level C anesthesia administered by an anesthesiologist or CRNA? If no, explain the qualifications of professionals administering general anesthesia:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Sterilization of Instruments and In-House Medical Emergencies for Surgical Procedures</b>	
5. Are surgical procedures provided? If yes, answer the following questions. If no, proceed to section L.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Are instruments sterilized on site? If yes, specify which method.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Steam Sterilization <input type="checkbox"/> Gas Sterilization <input type="checkbox"/> Chemical Soak <input type="checkbox"/> Routine Flash Sterilization	
7. Are written protocols in place for daily autoclave testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is each sterilized pack marked with the date of sterilization and expiration date?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Are all clinical staff CPR trained or higher?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Is there documented protocol for handling in-house medical emergencies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Is there an agreement with a local hospital for emergency transfers? If yes, what is the distance and length of travel time between your facility and this hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Is there an agreement in place with an ambulance company for transportation of emergency cases?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Is emergency equipment tested routinely with documentation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Questions 14, 15 and 16 should be answered if anesthesia is administered.</b>	
14. Are all medications in the ACLS Algorithm available on the emergency cart?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15. Are malignant hypothermia drugs available?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16. Is a copy of the ACLS Malignant Hypothermia Algorithm maintained on the cart?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**FOR SECTIONS L THROUGH W, COMPLETE THE SECTIONS THAT APPLY. SPECIFY NA IF NOT APPLICABLE.**

H. BARIATRIC SURGERY	
<input type="checkbox"/> NA	
1. Specify the number of procedures performed annually:	
2. What is the age range of patients undergoing bariatric surgery?	
3. How long has the Policyholder been performing bariatric procedures?	
4. On average, what percentage of procedures have complications?	
5. What percentage of procedures are laparoscopic?	
6. Check those organizations whose guidelines you follow:	
<input type="checkbox"/> American Society for Metabolic and Bariatric Surgery	
<input type="checkbox"/> Society of American Gastrointestinal and Endoscopic Surgeons	
<input type="checkbox"/> American College of Surgeons	
<input type="checkbox"/> Other (specify):	
7. Are the credentialing guidelines of the American Society for Metabolic and Bariatric Surgery and the Society of American Gastrointestinal and Endoscopic Surgeons being followed? If no, explain the in the Comments section.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I. BEHAVIORAL HEALTH <span style="float: right;"><input type="checkbox"/> NA</span>		
1. Check all services provided:		
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Psychodrama Therapy	<input type="checkbox"/> Massage Therapy
<input type="checkbox"/> Addiction/Dependency Treatment	<input type="checkbox"/> Criminal/Domestic Violence	<input type="checkbox"/> Nutritional/Eating Disorders
<input type="checkbox"/> Aversion Therapy	<input type="checkbox"/> Electroconvulsive Therapy (ECT)	<input type="checkbox"/> Psychotherapy/Psychoanalysis
<input type="checkbox"/> Biofeedback/Neurofeedback	<input type="checkbox"/> Genetic Counseling	<input type="checkbox"/> Recreation Therapy
<input type="checkbox"/> Boot Camp/Wilderness Survival Trng	<input type="checkbox"/> Hippotherapy	<input type="checkbox"/> Sexual Therapy
<input type="checkbox"/> Case Management/Social Services	<input type="checkbox"/> Learning/Developmental Disabilities	<input type="checkbox"/> Spiritual/Religious Counseling
<input type="checkbox"/> Counseling	<input type="checkbox"/> Life Coaching	<input type="checkbox"/> Grief Counseling
<input type="checkbox"/> Art/Dance/Drama/Music Therapy	<input type="checkbox"/> Marriage/Family Therapy	<input type="checkbox"/> Trauma Counseling
<input type="checkbox"/> Grief Counseling	<input type="checkbox"/> Vocational Counseling	<input type="checkbox"/> Rehabilitation Counseling
<input type="checkbox"/> Medication Management	<input type="checkbox"/> Other(describe):	
2. Does the Policyholder treat high-risk patients, including suicidal ideation, substance abuse, severe mental illness? If yes, describe in the Comments section.		<input type="checkbox"/> Yes <input type="checkbox"/> No

J. COLLEGE/UNIVERSITY HEALTH CENTER, COMMUNITY HEALTH CENTER, CONVENIENCE CARE/RETAIL CLINIC, MUNICIPAL HEALTH CENTER, URGENT CARE CENTER <span style="float: right;"><input type="checkbox"/> NA</span>		
1. Check all services provided:		
<input type="checkbox"/> Emergency Care	<input type="checkbox"/> Surgery	<input type="checkbox"/> Obstetrical Deliveries
<input type="checkbox"/> X-Ray/Imaging Services	<input type="checkbox"/> Pediatric Primary Health Care	<input type="checkbox"/> Nutritional/Eating Disorders
<input type="checkbox"/> Invasive Procedures/Minor Surgery	<input type="checkbox"/> Prenatal Care	<input type="checkbox"/> Abortions
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Genetic Counseling	<input type="checkbox"/> Pharmacy
2. Does the Policyholder have a referral network for patients who are in need of further treatment?		<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does the Policyholder provide follow-up patient status calls?		<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Does the Policyholder provide instructions for after-hours care?		<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Does the Policyholder dispense controlled narcotics?		<input type="checkbox"/> Yes <input type="checkbox"/> No

K. HOME HEALTH CARE <span style="float: right;"><input type="checkbox"/> NA</span>		
1. Specify the current number of patients:		
2. Are services provided under the direction and supervision of a physician based on physician orders and plan of care?		<input type="checkbox"/> Yes <input type="checkbox"/> No
3. How often are status reports given to the ordering physicians?		
4. Describe back-up procedures if assigned staff is not available to make a scheduled visit (include how absence is detected, who is assigned to cover and timeliness):		
5. What is the typical daily visit load for a full-time nurse (include number of patients seen per day):		
6. Is annual in-service training documented for all healthcare staff?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, indicate which training areas are included:		
<input type="checkbox"/> High-technology equipment areas	<input type="checkbox"/> Safe client lifting, transferring and ambulating techniques	
<input type="checkbox"/> Proper use of equipment	<input type="checkbox"/> Infection control and safety	
<input type="checkbox"/> Managing emergencies	<input type="checkbox"/> Other (explain):	

L. LABORATORY <span style="float: right;"><input type="checkbox"/> NA</span>		
1. What types and complexity of testing are performed?		
2. Does the Policyholder provide any of the following services? <input type="checkbox"/> Cytology <input type="checkbox"/> Paternity Testing <input type="checkbox"/> Assisted Reproductive Treatment/Techniques		
3. Is sperm or embryo storage provided?		<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is the Policyholder certified by CLIA (Clinical Laboratory Improvement Amendments)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
5. What is the process for reporting and communicating critical or abnormal results?		

**M. LITHOTRIPSY**  NA

1. Does the Policyholder provide any of the following types of services? If yes, indicate the annualized visits.
- |  |  |                    |
|--|--|--------------------|
| Ureterolithotomy (Open surgery)                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Annualized Visits: |
| Nephrolithotomy (Open surgery)                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Annualized Visits: |
| Pyelolithotomy (Open surgery)                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Annualized Visits: |
| Any other type of open surgery (Describe in Comments section.) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Annualized Visits: |
2. Is lithotripsy performed on children (under age 18)? If yes, please answer the following questions.  Yes  No
- How many children are treated on an annual basis?
  - Is treatment modified to consider the age of the patient?  Yes  No

**N. PHARMACY**  NA

1. Does the Policyholder manufacture any drugs or drug products?  Yes  No
2. Are any of the following services provided? Specify if not applicable.  NA
- |   |   |                                      |
|---|---|--------------------------------------|
| <input type="checkbox"/> Administration of medication | <input type="checkbox"/> Case management    | <input type="checkbox"/> Compounding |
| <input type="checkbox"/> Pain management              | <input type="checkbox"/> Patient monitoring |                                      |
- If any of these services are provided, further describe the service in the Comments section and include the percentage these services represent in comparison to all services provided.

**O. REHABILITATION**  NA

1. Check all services provided:
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Aquatic Therapy        | <input type="checkbox"/> Occupational Therapy  | <input type="checkbox"/> Social Services           |
| <input type="checkbox"/> Athletic Training      | <input type="checkbox"/> Orthotics/Prosthetics | <input type="checkbox"/> Speech/Language/Audiology |
| <input type="checkbox"/> Cardiac Rehabilitation | <input type="checkbox"/> Physical Therapy      | <input type="checkbox"/> Sports Medicine           |
| <input type="checkbox"/> Cognitive Therapy      | <input type="checkbox"/> Recreational Therapy  | <input type="checkbox"/> Trauma Rehabilitation     |
| <input type="checkbox"/> Driving, Adaptive      | <input type="checkbox"/> Sexuality Therapy     | <input type="checkbox"/> Vocational Training       |
| <input type="checkbox"/> Hippotherapy           | <input type="checkbox"/> Other (describe):     |  |
2. Are diagnostic services provided?  Yes  No  
If yes, indicate the type of diagnostic services provided and the percentage of total patients being diagnosed:
3. Do any patients require skilled medical care and/or life support apparatus?  Yes  No  
If yes, indicate the type of patients and the percentage of total patients requiring this type of care:
4. Are cardiac rehabilitation services provided? If yes, answer the following questions.  Yes  No
- |   |  |
|---|--|
| a. Are AACVPR guidelines followed?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b. Is a physician available on the premises when the program is in operation?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c. Are patients screened with a stress test?                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d. Are all exercises prescribed by a physician or exercise physiologist?        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| e. Is staff certified in BLS and ACLS?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| f. Is emergency equipment (defibrillator, O2, emergency medications) available? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| g. How often is emergency equipment checked?                                    |  |
| h. Are there written emergency protocols?                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| i. Are mock code drills conducted?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- Explain all "no" answers in the Comments section.

**P. SLEEP LAB**  NA

1. Indicate the percentage of sleep studies administered in each setting:
- In lab:
- At home:
- Other (specify):
2. Do all professionals have a valid CPR certification?  Yes  No
3. What is the patient to staff ratio?
4. How many technicians are certified by the Board of Registered Polysomnographic Technologists?

5. Is there a mechanism to visually monitor and record patients during testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do medically unstable patients have a nurse in attendance during the sleep study?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do pediatric patients and patients who need assistance with daily living activities have a guardian or caregiver in attendance during the sleep study?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Are patients referred by a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Who performs the screening prior to admitting a patient for a sleep study?	
10. Does the Policyholder have written policies and procedures for all technical procedures?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Q. SURGERY CENTER (INCLUDES ENDOSCOPY SERVICES)  NA**

1. Are patients screened to determine they are low-risk and are able to withstand having a surgical procedure performed on an outpatient basis? If yes, who performs the screening?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does the Policyholder provide any of the following types of services? If yes, indicate the annualized number of visits.	
Abortion <input type="checkbox"/> Yes <input type="checkbox"/> No Annualized Visits:	
Bariatrics <input type="checkbox"/> Yes <input type="checkbox"/> No Annualized Visits:	
Cardiac Catheterization <input type="checkbox"/> Yes <input type="checkbox"/> No Annualized Visits:	
3. Specify annual percent of patients for each patient classification:	
<b>ASA Physical Status Classification</b>	<b>Annual Percent of Patients</b>
P1–Normal healthy patient	%
P2–Patient with mild systemic disease	%
P3–Patient with severe systemic disease	%
P4–Patient with severe systemic disease that is a constant threat to life	%
P5–Moribund patient who is not expected to survive without the operation	%
P6–Declared brain-dead patient whose organs are being removed for donor purposes	%
4. Is the surgeon required to discuss the procedure and consent with the patient prior to the procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**R. WEIGHT LOSS CENTER  NA**

1. Describe the services offered:	
2. Are patients examined by a physician prior to starting any diet or exercise program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are services provided under the direction of a physician based on physician orders and plan of care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is there a fitness center on site? If yes, is it open to the public? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, annual revenue: \$ Describe the exercise facility in the Comments section including equipment and classes offered.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Does the Policyholder sell vitamins, food supplements or beverages to patients? If yes, please describe in the Comments section including annual gross revenue.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does the Policyholder advocate the use of weight loss drugs? If yes, use the Comments section to explain the type of screening performed on patients using drugs, the monitoring of patients and the types of drugs used.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Does the Policyholder sell or prescribe weight loss drugs? If yes, use the Comments section to explain the type of screening performed on patients using drugs, the monitoring of patients, the types of drugs used and annual gross revenue.	<input type="checkbox"/> Yes <input type="checkbox"/> No

**S. X-RAY / IMAGING CENTERS  NA**

1. Does the Policyholder provide any of the following services? Specify if not applicable: <input type="checkbox"/> NA <input type="checkbox"/> Interventional Therapy <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> IV Contrast	
2. Is there an external peer review program for high risk/high volume studies/images? If no, describe the peer review process in the Comments section.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does the Policyholder provide: <input type="checkbox"/> initial read <input type="checkbox"/> over-read/second reads <input type="checkbox"/> external peer review services	
4. Does the Policyholder provide teleradiology services? If yes, answer the following questions.	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Does the Policyholder offer these services to patients in states outside of your primary location? If yes, list each state:	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Is the “reading” physician licensed in all states in the service area?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Does the reading physician reside outside of the U.S. and its territories?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**T. CLAIM INFORMATION**

1. Are you aware of any claims, suits or potential claims that have not been reported to us? If yes, provide a description of each claim(s) in the Comments section and answer the following: a) Will the claim(s) be reported to us? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA b) If no, provide explanation (e.g. is this claim covered by a different insurance carrier?):	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> N/A
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**U. COMMENTS SECTION**

**Please include section and question number.**

I declare the information provided herein is complete and accurate. Providing false or misleading information may result in limiting or voiding coverage. I acknowledge a duty to timely inform you of any changes to answers provided herein.

_____	_____	_____
Policyholder Signature	Title	Date
_____		
Print Signature		