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Application

MEDICAL FACILiTIES AND PROVIDERS IMAGING CENTERS SUPPLEMENTAL APPLICATION

This Supplemental Application is part of the Medical Facilities and Providers Liability Application.

A. ACCOUNT INFORMATION

1. Applicant Name (as identified in the Medical Facilities and Providers Liability Application):	

B. OPERATIONS AND ADMINISTRATION

2. Please describe the types of imaging performed:

Question		
3. Does the Applicant have a formal fall prevention program that identifies high-risk patients?	☐ Yes	☐ No
4. Does the Applicant have a policy that forbids elderly or disoriented patients from being left unattended by staff?	☐ Yes	☐ No
5. Does the Applicant have a policy or system for properly matching the right patient with the right diagnostic procedure?	☐ Yes	☐ No
6. Are the results read by an employed or contracted radiologist?	☐ Employed	☐ Contracted
7. Are the results sent on the facility's letterhead?	☐ Yes	☐ No
8. Does the Applicant have policies and procedures established outlining the process for communicating the results to the patient and the patient's practitioner (letters, documented phone calls etc.)?	☐ Yes	☐ No
9. Does the Applicant have a comprehensive quality assurance/safety program that includes calibrating equipment, identifying operating irregularities, utilizing controls/phantoms, etc.?	☐ Yes	☐ No

Magnetic Resonance Imaging Services – Please complete the following questions if applicable:

Question		
10. Does the Applicant have policies and procedures established regarding patients who cannot be safely scanned by MRI?	☐ Yes	☐ No
11. Are all patients thoroughly assessed to ensure they can safely undergo an MRI (i.e. patient/surrogate interview, review of medical records, use of an MRI questionnaire, etc.)?	☐ Yes	☐ No
12. Does the Applicant have a written and rehearsed procedure for handling cardiac and/or respiratory arrests? (i.e. system shut down, patient removed from area, responding staff cannot enter area, etc.)	☐ Yes	☐ No

C. SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, declares that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplemental Application and any attachments of information submitted with this Supplemental Application are true and complete. The undersigned understands that information submitted herein becomes part of the Applicant's Medical Facilities and Providers Liability Application and is subject to the representations and conditions set forth therein.

NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	

NOTE: THIS APPLICATION MUST BE SIGNED BY THE CHIEF EXECUTIVE OFFICER, PRESIDENT, CHAIRMAN OR OTHER OFFICER OF THE APPLICANT ACTING AS THE AUTHORIZED AGENT OF ALL INDIVIDUALS AND ENTITIES PROPOSED FOR THIS INSURANCE.