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Application

MEDICAL FACILITIES AND PROVIDERS PHARMACY 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. FINANCIAL AND EXPOSURE DETAILS

2. Type of Operation:

Services	Percentage of Gross Receipts	Services	Percentage of Gross Receipts
Administration of Medication/Infusion	%	Pain Management	%
Case Management	%	Patient Monitoring	%
Closed Pharmacy	%	Pharmacy Benefit Management	%
Compounding	%	Re Packaging	%
Contract Pharmacy	%	Point of Care Dispensing	%
Consulting to 3rd Party/Pharmacy Mgmt	%	Remote Monitoring	%
Disease Mgmt Programs	%	Research/Clinical Trials	%
Dispensing	%	Retail Pharmacy	%
Drug Formulary Mgmt Programs	%	Specialty Pharmacy	%
Home Respiratory Providers	%	Staffing/Hospital Pharmacy Dept	%
Laboratory Services	%	Staffing Other Pharmacy	%
Manufacturing	%	Other (Describe): ________________	%
Medical Equipment Sales	%		

3. Annual Gross Receipts:

	Last 12 Months	Projected for Next 12 Months
Prescription Sales	$	$
Sundries Sales	$	$
Medical Equipment Sales	$	$
Medical Equipment Rental	$	$
Infusion/In Home Therapy	$	$
OTC Medications	$	$
Other: ____________________________	$	$
Total	$	$

4. Number of Prescriptions:

Last 12 Months ____________

Projected for Next 12 Months ____________

C. OPERATIONS AND ADMINISTRATION

5. Is the Applicant a member of the Institute for Safe Medication Practices (ISMP)? ☐ Yes ☐ No

6. Does the Applicant have access to drug information (i.e. Drug Facts and Comparisons, Micromedex, etc.)? ☐ Yes ☐ No

7. Are all prescriptions authorized by a licensed physician licensed in the state where services are rendered? ☐ Yes ☐ No

8. Does the Applicant provide mail order or internet pharmacy services, or accept electronic prescriptions? ☐ Yes ☐ No

   If "Yes," provide details of safety controls used to assure a licensed physician has authorized prescriptions.

9. Before a drug is dispensed, does the Applicant always require and verify the following patient information:

   a. Patient identifiers (name, address, date of birth, etc.) ☐ Yes ☐ No

   b. Drug history (including herbals, dietary supplements, etc) ☐ Yes ☐ No

   c. Allergies, and other chronic conditions as well as medical history ☐ Yes ☐ No

10. Are all prescriptions dispensed with current written instructions? ☐ Yes ☐ No

11. Are telephone orders only taken by a pharmacist from authorized professional staff and repeated back to the prescriber for verification? ☐ Yes ☐ No

12. Are pharmacists and technicians trained in the procedure for responding to a serious medication error which includes immediate disclosure to the patient and notification to the prescribing practitioner? ☐ Yes ☐ No

13. Are criteria established (i.e. targeted high-alert drugs, patient population) to trigger required medication counseling (i.e. alert tag on bag)? ☐ Yes ☐ No

14. Are products with known look-alike drug name stored separately and not alphabetically? ☐ Yes ☐ No

15. Are special alerts contained in the system to address problematic or look-alike drug names, packaging or labeling? ☐ Yes ☐ No

16. Does the Applicant's computer system perform pediatric dose range checks? ☐ Yes ☐ No

17. Does the Applicant's computer system detect drug contradictions, interactions, duplications against medical history and other prescribed drugs? ☐ Yes ☐ No

18. If the Applicant compounds in bulk, manufactures or wholesales drugs or products, are active ingredients purchased from chemical factories that are registered with the FDA? ☐ Yes ☐ No

D. 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.