Professional Liability Application for Certified Registered Nurse Anesthetist – CRNA Staffing

westwood insurance group

Send submissions to submissions@westwoodinsurancegroup.com

Instructions: Answer all questions; applicant's name must include the names of all businesses and locations for which coverage is desired. If the answer is none, state none. If the answer is not applicable, state not applicable (N/A). If the space provided is insufficient to fully answer the question, please attach a separate sheet.

Note: Application must be dated and signed by owner, partner, officer, or administrator.

Please type or print in ink.

Part I. General Information

1.1 Applicant Name (including DBAs): _____

1.2 Mailing Address: _____

_____

1.3 Location Address(es): _____

_____

1.4 County (parish) of Each Location: _____

1.5 Telephone Number: Office: _____ Fax: _____

1.6 Person to Contact for Survey: Name: _____ Title: _____

1.7 Year Entity Established: _____

1.8 Entity is: ☐Individual ☐Corporation ☐Partnership ☐Professional Association/Corporation
☐Other; Describe: _____

1.9 Entity is: ☐For Profit ☐Non-Profit
Describe Source of Funds: _____

1.10 Entity is: ☐Medical Personnel Staffing (Home Health Care Services Only)
☐Medical Personnel Staffing (All Other)
☐Other; Describe: _____

1.11 Accreditation Information (check whichever applies):
Type: ☐SAS Distinguished or Gold Standards ☐SAS Full Accreditation
☐Other; Describe: _____

1.12 Proposed Effective Date: _____

1.13 Requested Limits of Liability (if available):
Professional Liability: $_____/$_____
General Liability: $_____ Each Occurrence
$_____ General Aggregate

1.14 Annual Gross Receipts: Estimated Next 12 Months: $_____
Last 12 Months: $_____

1.15 Total premises square footage occupied by applicant: _____

1.16 List all memberships in professional organizations: _____

_____

_____

Part II. Exposures

2.1 Indicate the next 12 months estimated hours worked and compensation for employed staff:

2.1.1 **Employed Staff (W-2):**

Type	Maximum No.	Annual Hours of Service	Annual Payroll
CRNA			$
Assistant Anesthetist			$
Other:			$
Employed Subtotal:			$

2.1.2 **Contracted Staff (1099):**

Type	Maximum No.	Annual Hours of Service	Annual Payroll
CRNA			$
Assistant Anesthetist			$
Other:			$
Contracted Subtotal:			$
Total:			$

2.1.3 Does the applicant desire to provide coverage for independent contractor(s) (including them as additional insured(s) on your policy while working on your behalf)? ☐Yes ☐No

2.1.4 Enter percentage of services provided by category of staff, including contracted staff:

CRNAs

_____% Hospitals

_____% Surgicenters

_____% Other; Describe: _____

Assistant Anesthetist

_____% Hospitals

_____% Surgicenters

_____% Other; Describe: _____

Other: _____

_____% Hospitals

_____% Surgicenters

_____% Other; Describe: _____

Other: _____

_____% Hospitals

_____% Surgicenters

_____% Other; Describe: _____

2.2 Number of estimated patients next 12 months: _____

2.4 Number of patients last 12 months: _____

2.5 Is your facility owned by an M.D.? ☐Yes ☐No

If yes, owner name(s): _____

2.6 Do you sell, rent, or otherwise provide any equipment or products to patients? ☐Yes ☐No

To others? ☐Yes ☐No

If yes, to either question, complete Product Sales/Rental Supplement.

2.7 Is the applicant eligible for certification or accreditation? ☐Yes ☐No

If yes, is applicant certified and/or accredited? ☐Yes ☐No

If no, explain the reason: _____

_____

2.8 Is applicant approved to receive Medicare and Medicaid payments? ☐Yes ☐No

Part III. Risk Management

3.1 Name, qualifications, and number or years of experience of the Medical Director:

Name	Title	Experience/Training	Association Membership

3.2 Does your agency have a written credentializing policy and procedure for all individuals associated with or practicing within the agency? ☐Yes ☐No

3.3 Do you conduct pre-employment screening and investigation? ☐Yes ☐No

3.4 Does the staff supervisor make regular audit visits of staff in the field? ☐Yes ☐No

Who does the supervising of staff, and what is his/her experience? _____

3.5 Do you require contracted staff (if any) to carry their own Professional Liability Insurance? ☐Yes ☐No

Do you secure Certificates of Insurance as evidence of such coverage? ☐Yes ☐No

3.6 Describe the referral source(s) by which patients are directed to the entity: _____

3.7 Do you enter into any contractual agreements (other than lease of premises agreements) in which you hold others harmless? If yes, attach copies of all such contracts. ☐Yes ☐No

3.8 Does the agency advertise its services other than an ordinary local telephone directory listing? If yes, please attach a copy of each advertisement. ☐Yes ☐No

3.9 Do you maintain a written clinical record showing the total number of visits by each category of staff for each patient or organization client? ☐Yes ☐No

3.10 Is any staff provided to hospitals specifically to serve a particular specialty (e.g., OR, ICU, CCU, ER, etc)? ☐Yes ☐No

If yes, enter percentage of services provided, by category, of staff including contracted staff:

_____ % OR

_____ % Labor/delivery

_____ % ICU/CCU

_____ % ER

_____ % Other; Describe: _____

3.11 Does your agency have a written incident/occurrence reporting policy and procedures? ☐Yes ☐No

3.12 Does your facility require the professional staff be trained in CPR? ☐Yes ☐No

3.13 Do you prepare job descriptions and instructional manuals for your staff? ☐Yes ☐No
If yes, enclose a copy of each.

3.14 Do you maintain records of specific areas of experience of each staff member? ☐Yes ☐No

3.15 Is the applicant and all professional employees licensed in accordance with applicable state and federal laws? If no, attach explanation of any exception. ☐Yes ☐No

3.16 Has the applicant or any of its employees:

a) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital, or professional association? ☐Yes ☐No

b) Had any professional license refused, suspended, revoked, renewal refused, or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? ☐Yes ☐No

c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐Yes ☐No

If the answer to any of 3.16 is yes, please attach a detailed explanation.

3.17 Please describe in detail any additional operations, business pursuits, or joint ventures in which your facility is currently engaged which would fall outside the scope of typical home health care operations. ☐None ☐Description Attached

Part IV. History

4.1 List prior professional liability insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	Claims-Made No
1.						
2.						
3.						
4.						
5.						

If claims-made, what is the most recent retroactive date? _____

4.2 List prior general liability insurers for the past five years, starting with the most recent year. If none, state none.

Insurer	Policy Number	Limits of Liability	Premium	Eff. Date	Claims-Made Yes	Claims-Made No
1.						
2.						
3.						
4.						
5.						

If claims-made, what is the most recent retroactive date? _____

4.3 Have any claims been made or occurrences reported during the past six years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? ☐Yes ☐No

If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved (attach an additional sheet if necessary): _____

4.4 Does any proposed insured have any knowledge of an event, circumstance, or occurrence (other than any listed in 4.3 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance, or occurrence? ☐Yes ☐No

If yes, describe the event and indicate the reason for anticipation of a claim:

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation, and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and ProAssurance Mid-Continent Underwriters, Inc., any documents, records, or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information which is calculated to influence the judgment of the insurance company in considering this application.

Important: This application must be signed by the applicant. Signing this form does NOT bind the company to complete the insurance.

Date	Applicant Signature/Title

Medical Products Sales or Equipment Rental Supplemental Application

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A. List each product or equipment line individually and provide receipts for each. Attach a copy of your products/equipment brochures.

Describe Product/Equipment Line	Annual Receipts From Rental	From Sales
1.		
2.		
3.		
4.		
5.		

B. Describe clients applicant sells/rents to, and % each:

_____% Individuals using products in their home
_____% Individuals in nursing homes*
_____% Nursing homes or similar residential facilities*
_____% Hospitals*
_____% Clinics/labs*
_____% Physicians*
_____% Other*; Describe _____

* If other than individuals in their home, is there a financial/ownership relationship between applicant and client or facility? ☐ Yes ☐ No If Yes, explain: _____

C. Who does the servicing and repair of the products? _____

Who does the servicing and repair of rental equipment? _____

D. Are any products manufactured by others and sold under your entity's label? ☐ Yes ☐ No

If yes, which products? _____

E. Are any additional products planned in the next twelve months? ☐ Yes ☐ No

If yes, include them under question A, and estimate the receipts in the next 12 months.

F. How are products marketed? (attach ad copy or brochures) _____

_____

G. Is a rental/lease agreement signed by customers prior to releasing any rental equipment? ☐ Yes ☐ No
If yes, please enclose a copy of the rental agreement.

H. Is formal written inspection program for rental equipment conducted prior to each rental? ☐ Yes ☐ No

I. Are manufacturer's labels/directions/instructions provided to customers for all rentals? ☐ Yes ☐ No

J. Do the manufacturers or distributors of any of the above listed items:

1) Name your entity as an additional insured under their products liability policies? ☐ Yes ☐ No
2) Provide Certificates of Insurance for Products Liability to you? ☐ Yes ☐ No
3) Provide maintenance/service agreements for their product(s)? ☐ Yes ☐ No
4) Hold you harmless for loss arising from their products? ☐ Yes ☐ No

If the answer is yes for some products, please specify which product line and which answers: _____

_____

K. Are all manufacturers/suppliers well-known U.S. firms? ☐ Yes ☐ No If no, give details of which are not and any foreign products: _____

L. If sales of medicines or drugs are made by applicant, is a licensed pharmacist employed or contracted? ☐ Yes ☐ No

If, yes indicate number: _____ Employed (W-2) _____ Contracted (1099)

Does pharmacist carry his/her own professional liability insurance? ☐ Yes (Limits: _____) ☐ No

_____ _____

Date Signature/Title