

AMBULATORY SURGICAL FACILITIES UNDERWRITING INFORMATION FORM

IMPORTANT: Please do not leave any questions incomplete. Unanswered questions or incomplete information including requested supporting documents will delay the underwriting of your application. Please print or type your answers.

1. Name of facility: _____
Address: _____
City: _____ State: _____ Zip: _____ Telephone: _____
2. Name of insurance company that provides professional liability insurance:

3. Is the facility licensed and/or accredited by any agency? Yes No
If "Yes," please indicate agency name: _____
If you are not currently accredited, are you eligible for and have you applied for accreditation? Yes No
If you are not eligible for accreditation at this time, do you follow guidelines issued by a specific accrediting agency? Yes No
If "Yes," please indicate the name of accrediting agency: _____
4. Name and title of person who directs and supervises the physician staff:

5. Name and title of person who directs and supervises the ancillary personnel:

6. Are complete medical histories taken and physical examinations conducted (including necessary pathological tests) prior to all procedures performed at facility? Yes No
If "No," please explain: _____
7. Are the patient's written authorization for the specific surgical procedure(s) and the patient's written "informed consent" obtained prior to surgery? Yes No
If "No," please explain: _____
8. Are the above-referenced items made a part of the patient's clinical record and maintained at the facility? Yes No
9. Indicate the number of operating rooms in the facility: _____
10. Indicate the number of recovery rooms (including number of beds) in the facility: _____
11. Is "overnight" stay permitted at the facility? Yes No
12. In the event of complications, what are the emergency handling procedures at the facility?

13. With what hospital(s) has the facility a "transfer agreement" for handling of emergency cases?

14. What is the travel time and distance (in miles) to this hospital? _____
15. Can at least one member of your staff initiate CPR and begin advanced life support? Yes No
16. Please indicate which of the monitors below are used in the facility during surgical procedures:
 EKG
 Precordial stethoscope
 Blood pressure device
 Other
 Ability to monitor temperature (for general anesthesia)
 Oxygen analyzer (for general anesthesia)

17. Do you have a back-up power system? Yes No
18. Please indicate if any of the following equipment is used in the facility:
- Suction adequate for tracheal suctioning
 - A source for delivering oxygen throughout a surgical procedure
 - Equipment for endotracheal intubation
 - A defibrillator
19. Do you have drugs and supplies for treating cardiopulmonary emergencies? Yes No
20. If general anesthesia is used at the facility, are drugs and supplies readily available to initiate the treatment of malignant hyperthermia?
 Yes No
21. Please check each type of anesthesia care that is used at the facility:
- Local anesthetic and minor regional blocks (e.g., digital nerve block)
 - Conscious sedation/analgesia (see last page for definition)
 - Deep sedation/analgesia (see last page for definition)
 - General anesthesia (see last page for definition)
 - Major regional anesthesia:

<input type="checkbox"/> Interscalene	<input type="checkbox"/> Supraclavicular
<input type="checkbox"/> Axillary	<input type="checkbox"/> IV regional
<input type="checkbox"/> Spinal	<input type="checkbox"/> Epidural
 - Other: _____
22. Please indicate who provides sedation/analgesia/anesthesia at your facility:
- | | |
|---|---|
| <input type="checkbox"/> Surgeon | <input type="checkbox"/> CRNA |
| <input type="checkbox"/> RN | <input type="checkbox"/> Anesthesiologist |
| <input type="checkbox"/> Surgical Assistant | <input type="checkbox"/> Other: _____ |
23. Please indicate whether children will have surgical procedures performed at your facility:
- Children under 5 years of age
 - Children over 5 years of age
24. Please indicate the health status of patients who will have surgical procedures at your facility:
- Healthy patients only (i.e., patients with absolutely no systemic diseases)
 - Patients with mild systemic diseases (e.g., mild HTN)
 - Patients with more severe systemic diseases who are stable (e.g., well-compensated CHF)
25. Please provide a list on a separate sheet of all physicians who have been granted privileges to perform procedures at the facility and indicate their medical specialty. Also, confirm that they have hospital privileges to perform all procedures.
26. Have privileges been granted to other licensed health care providers (e.g., dentist, podiatrist)? Yes No
 If "Yes," please indicate type of professional(s): _____
27. Please attach a copy of a current listing of all procedures performed in the facility.
28. Please attach a copy of a patient brochure, if available.

 Applicant's Signature

 Date

Washington State law requires us to inform you of the following: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

I understand that signature of this application does not bind the company to complete this insurance.

(A photocopy or facsimile of this Authorization shall be considered as effective and valid as the original.)

CLAIM INFORMATION

(NOTE: please make copies of this form for additional claims)

1. Name of patient: _____ 2. DOB: _____ 3. Sex: _____

4. Allegation: _____

5. Date of incident: _____ 6. Date reported: _____

7. Insurance carrier: _____
Was a lawsuit filed? Yes No

8. Additional defendants: _____

9. Location of occurrence: _____

10. Disposition of claim: _____

11. Amount of settlement or judgment: _____
If claim is still open, reserve amount: _____

The following questions should be answered in adequate clinical detail to allow proper evaluation. Please attach copies of patient's charts and operative notes as appropriate. Attach additional sheets as required, in duplicate.

12. Condition and diagnosis at time of incident: _____

13. Date and description of treatment rendered: _____

14. Condition of patient subsequent to treatment: _____

I understand information submitted herein becomes part of my Professional Liability Insurance Application as submitted.

Applicant's Signature*

Date

* Signature line must be signed and dated even if you have no claims to report.

Please return to:

Seattle Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
PO Box 91220
Seattle, WA 98111
(206) 343-7300 (800) 962-1399
F (206) 343-7100

Eastern Regional Office:
Physicians Insurance A Mutual Company
Attn: Underwriting Department
421 W. Riverside Avenue, Suite 1200
Spokane, WA 99201
(509) 456-5868 (800) 962-1398
F (509) 456-0821

