



**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.**