



**SUPPLEMENT APPLICATION
MEDICAL TESTING LABORATORIES**

(Please note that this Supplemental Application must be completed for each facility/location. The Medical Facilities Professional Liability Coverage Application must be completed and submitted with all Supplemental Applications).

NAME OF FACILITY: _____

ADDRESS: _____

I. LICENSING:

A. Is the applicant licensed to do business in the states where required? Yes No

B. If YES, please provide: Yes No

1. Name on License: _____

2. Licensed by state of: _____

3. License # _____

4. Expiration Date: _____

Please provide copy of the current license with this application

C. Has license ever been revoked, suspended, placed on probation or restricted in anyway? Yes No

If YES, please explain: _____

II. GENERAL INFORMATION:

A. Is facility certified for Medicare/Medicaid? Yes No

If YES, please list your Provider Numbers: Medicare _____

Medicaid _____

B. Is the facility CLIA Certified? Yes No

If YES, type of Certificate: _____

C. Is the facility accredited by College of American Pathologists? Yes No

If YES, date: _____

- D. Are you accredited by any other organizations? Yes No
 If yes, by whom: _____
- E. Is the facility affiliated with any correctional or penal facilities? Yes No
- F. Is applicant a full-time facility? Yes No
- G. Gross Receipts by Category:
 Cytology _____ Imaging _____ Drug Testing _____ All Other _____

H. Number of Treatments/Procedures

	Last Year	Prior Year
Cytology		
Imaging		
Drug Testing		
All Other		

- I. If a reference lab is used, what are the expected annual receipts for the reference lab: _____
 Reference lab name: _____
- Does the reference lab hold you harmless? Yes No
- Do you have proof of insurance with \$1,000,000 limit for the reference lab? Yes No

J. **If yes to any of the following, please attach explanation including number of tests/procedures and gross receipts:**

1. Test result interpretation in lab's name: Yes No
2. Consultation in lab's name: Yes No
3. Therapy or any treatment procedures: Yes No
4. Blood banking or blood storage: Yes No
5. Intravenous transfusions: Yes No
6. Procurement of blood or its components: Yes No
7. Plasmapheresis procedures: Yes No
8. Medical, genetic or drug research: Yes No
9. Any type of environmental analysis: Yes No
10. Manufacturing, dispensing or testing of pharmaceuticals: Yes No
11. Manufacture or sell laboratory equipment or supplies: Yes No
12. Experimental or research in nature: Yes No
13. Solely mobile in nature: Yes No
14. Any services to the public (health fairs, shopping mail exhibits, etc.): Yes No
15. AIDS or HIV testing: Yes No

If YES, Annual Receipts Expected In-House: _____
 Annual Receipts Expected Reference Lab: _____

- K. Do you provide any services under contract? Yes No
- L. Have any physicians with a financial relationship to the applicant ever made any medical referrals to the applicant? **"Financial relationship" means all ownership or investment interests, compensation arrangements, and medical directorships with applicant.** Yes No

If YES, please attach explanation (including name of physicians, details of financial relationship, type of referrals).

III TESTING INFORMATION: (if not applicable, so state)

A. DRUG TESTING

1. What are the expected receipts from drug testing? _____
2. Does applicant perform a second test if the first test is positive? Yes No
3. Does applicant or its client obtain the written consent of all people to be tested? Yes No
4. Do physicians review test results? Yes No
5. Briefly describe the test handling process (specimen collection, transportation, testing, reporting).

B. CYTOLOGY - We will require a Certificate of Insurance on the physician reviewing these tests.

1. Is all cytology work done per a physician's request? Yes No
2. Who reviews the tests? _____
3. Are the tests results sent to the treating physician for review? Yes No
4. Are abnormal and 1 0% of normal reviewed? Yes No
5. What are the expected receipts from cytology work? _____
6. Are technicians compensated on a per slide basis? Yes No

C. EKG

1. Are all EKG tests performed per a physician's request? Yes No
2. Who interprets the EKG'S? _____
3. Are they sent to the physician for review? Yes No
4. Are the tapes condensed by computer before being interpreted? Yes No
5. How is the EKG equipment maintained? _____
6. How often is it serviced? _____
7. Are portable holster monitors used? Yes No
8. What are the expected receipts from EKG work? _____

D. IMAGING - We will require a Certificate of insurance from your radiologist.

1. What testing substances are ingested or injected into the patient? _____
2. Is there a likelihood of adverse reaction to the substances? Yes No

3. What emergency medical procedures have you established in the event of such reactions?
Explain: _____
4. Describe the system of delivery and disposal of radio-nuclides. _____

5. Indicate the frequency of testing of air and water discharge from the facility to ascertain local, state and federal standards of compliance. _____
6. What are the qualifications and training of personnel? _____

7. Describe control and maintenance of equipment. _____

8. How are your x-ray records maintained? _____
9. Are the x-rays done per a physician's request? Yes No
10. Who performs the x-rays? _____
11. Who reports the interpretation of the x-ray? _____
12. Are the actual x-rays sent to requesting physician or just the report? _____
13. Are the x-rays sent out under the name of the laboratory or under the name of the radiologist?
 Yes No
14. How is the x-ray equipment maintained? _____
15. How often is it serviced? _____
16. What are the expected receipts for x-ray work? _____

IV. EMPLOYEE INFORMATION:

Physicians	Full-Time _____	Part-Time _____
X-Ray Technicians	Full-Time _____	Part-Time _____
Laboratory Technicians	Full-Time _____	Part-Time _____
Cytology Technicians	Full-Time _____	Part-Time _____
All Others:		
_____	Full-Time _____	Part-Time _____
_____	Full-Time _____	Part-Time _____

V. EMERGENCY & SAFETY PROCEDURES:

- A. How often are fire drills conducted? _____
- B. How are medical emergencies handled?
 1. On Call Physicians? Yes No
 2. Affiliated Physicians on Premises? Yes No
 3. Hospital and/or emergency center? Yes No
If YES, is hospital and/or emergency center located within a 15 minute drive under typical conditions?
 4. Other? Yes No
(explain) _____

C. Specify arrangements for storage and dispensing of drugs: _____

VI. STATE INSPECTION

A. Date of last State Inspection/Survey (if applicable): _____

B. Total # of Deficiencies: _____

C. Corrective Action Plan Accepted by State Yes No

Date Accepted: _____

D. Number of Complaints investigated by State the past 2 years : _____

E. Number of Substantiated complaints: _____

VII. PHYSICIAN INFORMATION

A. Please identify by name and function served, all physicians including (psychiatrists, osteopaths, dentists or chiropractors) employed or affiliated with the facility:

Name	Type of Doctor	Specific Duties in Facility Operations

B. Is your facility insured under the Professional Liability issued to each person specified above?

Yes No

Certificates of insurance for doctors will be required, so please state:

Name of Doctor	Insurance Carrier	Insurance Limit	Expiration date of Coverage

This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, and psychiatrist. These medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate.

I **DECLARE** that the information contained in this supplement is true and that no material facts have been suppressed or misstated.

I **UNDERSTAND** that an incorrect or incomplete response could void my coverage.

Signature of Applicant

Date