ADMIRAL INSURANCE COMPANY 520 Pike Street, Suite 2929 Seattle, WA 98101 Phone: (206) 467-6511 Fax: (206) 467-6577 http://www.admiralins.com	APPLICATION FOR AMBULATORY SURGERY CENTERS

1. Full Name of Applicant: _____

_____

(Include all dba's and subsidiaries seeking coverage under the policy for which you are applying.)

2. Mailing and Location Address: _____

_____

(If multiple addresses include an attachment with a complete schedule of all locations)

3. Website Address (if applicable): _____

4. Who coordinates your risk management program?

Name: _____ Title: _____

Telephone: (_____) _____ Email: _____

5. Date Established: _____

6. Type of Entity: ☐ Corp ☐ Partnership ☐ Individual ☐ Other: _____

7. Is this entity owned by, associated with or controlled by any other entity? ☐Yes ☐No
If Yes, please give details: _____

8. Limits Requested: $ _____ each claim / $ _____ aggregate

9. Deductible Requested: ☐ $5,000. ☐ $10,000. ☐ $15,000. ☐ $20,000. ☐ Other: $ _____

10. Please provide the number of employees or independent contractors and whether or not they carry their own individual medical malpractice coverage for their services on behalf of this entity:

	Employee or Volunteer	Independent Contractor	Insured On Own Med Mal Policy	Limits Required
Physicians	_____	_____	☐Yes ☐No	_____
Physician Assistants	_____	_____	☐Yes ☐No	_____
Surgical Technicians	_____	_____	☐Yes ☐No	_____
Certified Nurse Anesthetists	_____	_____	☐Yes ☐No	_____
Nurse Practitioners	_____	_____	☐Yes ☐No	_____
Registered Nurses	_____	_____	☐Yes ☐No	_____
LPN's or Nurse Aides	_____	_____	☐Yes ☐No	_____
X-Ray Technicians	_____	_____	☐Yes ☐No	_____
Medical Assistants	_____	_____	☐Yes ☐No	_____
Pharmacists	_____	_____	☐Yes ☐No	_____
Other: _____	_____	_____	☐Yes ☐No	_____

*Name of Medical Director and advise specialty: _____

a) Are the Medical Director's duties administrative only? ☐Yes ☐No
b) Does the Medical Director provide direct patient care? ☐Yes ☐No
c) What medical malpractice limits is Medical Director required to carry? _____

11. Are all of the above individuals licensed in accordance with applicable state and federal regulations? ☐Yes ☐No
If No, please attach a detailed explanation.

12. Has the applicant or any of the above employees and/or independent contractors:
If Yes, please attach a detailed explanation.
(a) Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or administrative agency, hospital or professional association? ☐Yes ☐No
(b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ☐Yes ☐No
(c) Ever been treated for alcoholism or drug addiction? ☐Yes ☐No
(d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? ☐Yes ☐No

13. Surgical category and estimated number of procedures (please provide totals at bottom):

Type of Procedure	**Number of Procedures**		
	Last Year	Current Year	Estimate Next Year
Abortions			
Bariatric (lap band only)			
Bariatric (all other)			
Cardiology			
Dermatology/ Non-Cosmetic			
Dermatology/ Cosmetic			
Endoscopy/Colonoscopy			
Gastroenterology			
General Surgery			
Gynecology			
Obstetrics			
Ophthalmology			
Oral/ Non-Cosmetic			
Oral/ Cosmetic			
Orthopaedic/ Incl. Hand/No Spine			
Orthopaedic/ Incl. Spine			
Otorhinolaryngology/Non-Cosmetic			
Otorhinolaryngology/Cosmetic			
Plastic/Cosmetic			
Plastic/Reconstructive			
Pain Management			
Podiatry			
Rheumatology			
Thoracic			
Urology			
Other: _____			
Other: _____			
Other: _____			
TOTALS:			

14. State sources and amounts of total revenue:

	Last 12 months	Estimate for next 12 months
Fee for service	$_____	$_____
Other:_____	$_____	$_____
Total Gross Revenues:	$_____	$_____

15. Is the facility Licensed? ☐Yes ☐No
Medicare Certified? ☐Yes ☐No
Accredited? ☐Yes ☐No If yes, by what accrediting body?_____

16. Is the patient's written authorization for the specific surgical procedure(s) and is the patient's written "informed consent" obtained prior to surgery? ☐Yes ☐No
If no, please explain:_____

17. Are the above referenced items made a part of the patient's clinical record and maintained at the facility? ☐Yes ☐No

18. Normal hours of operation:_____

19. Indicate the number of operating rooms in the facility:_____

20. Indicate the number of recovery rooms (including number of beds) in the facility:_____

21. Is "overnight" stay permitted at the facility? ☐Yes ☐No

22. In the event of complications, what are the emergency handling procedures at the facility?

_____

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

_____

24. What is the travel time and distance (in miles) to this hospital? _____

25. Can at least one member of your staff initiate CPR and begin advanced life support? ☐Yes ☐No

26. 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)

27. Do you have a back-up power system? ☐Yes ☐No

28. 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

29. Do you have drugs and supplies for treating cardiopulmonary emergencies? ☐Yes ☐No

30. If general anesthesia is used at the facility, are drugs and supplies readily available to initiate the treatment of malignant hyperthermia? ☐Yes ☐No

31. 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)
- ☐ General anesthesia (see last page for definition)
- ☐ Major regional anesthesia:
  - ☐ Interscalene
  - ☐ Supraclavicular
  - ☐ Axillary
  - ☐ IV regional
  - ☐ Spinal
  - ☐ Epidural
  - ☐ Other: _____

32. Please indicate who provides sedation/analgesia/anesthesia at your facility:
- ☐ Surgeon
- ☐ Surgical Assistant
- ☐ Anesthesiologist
- ☐ RN
- ☐ CRNA
- ☐ Other: _____

33. Please indicate whether children will have surgical procedures performed at your facility:
- ☐ Children under 5 years of age
- ☐ Children over 5 years of age

34. 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 disease)
    - ☐ Patients with mild systemic diseases (e.g. mild HTN)
    - ☐ Patients with more severe systemic diseases who are stable (e.g. well-compensated CHF)

35. Please provide a list of all physicians who have been granted privileges to perform procedures at the facility and indicate their medical specialty.

36. Are all physicians with privileges at your facility required to carry their own medical malpractice policy? ☐Yes ☐No
    If Yes, do you require proof of this insurance? ☐Yes ☐No If No, please

37. Do any physicians with privileges at your facility have medical malpractice coverage with a Risk Retention Group or Captive Insurance Company? ☐Yes ☐No If Yes, please provide the name of the physician(s) and their malpractice carrier.
    _____
    _____

38. Are all privileged physicians required to have admitting privileges at a hospital? ☐Yes ☐No

39. Please provide the following information as respects the last five years of **PROFESSIONAL LIABILITY** coverage beginning with the most current coverage:

Carrier	Limit	Deductible	Premium	Policy Term	Retroactive Date
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

40. Does the applicant carry General Liability Insurance? ☐Yes ☐No
    Are you interested in a quote for General Liability? ☐Yes ☐No If Yes, provide a schedule of locations and the square footage of each location.

41. Does the applicant own, operate or manage any business other than the one(s) described in this application for which you are applying for coverage? ☐Yes ☐No If Yes, please complete details, including name of entity, your ownership interest or contractual relationship and information on their insurance program. _____

42. Has any application for professional liability insurance made on behalf of the applicant, any predecessors in business or present partners ever been declined, cancelled or non-renewed? ☐Yes
    dates._____

43. Has any claim ever been made against the applicant or any of its employees? ☐Yes ☐No If Yes, how many? _____
    Please complete the Supplemental Claim Information Form at the end of this application for each and every claim.

44. Is the applicant aware of any circumstances which may result in any claim against them or their employees? ☐Yes ☐No
    If Yes, please provide full details on each incident including name of parties involved, date of treatment and current status of incident._____
    _____
    _____

45. Please provide a minimum of 5 years of currently valued carrier loss runs. If this is a new business, please send 5 years of currently valued carrier loss runs on the principal physician owner(s).

The applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell nor the applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statement and representations made in this application and this application will be made a part of the policy. The applicant understands that any subsequent contract issued by the Company will be issued on a claims made form.

_____ _____
Signature Date

_____ _____
Name (please print) Title

ANESTHESIA DEFINITIONS

For purposes of this questionnaire, the following are the definitions used relating to anesthesia:

***LOCAL ANESTHESIA** - The elimination of pain in one part of the body by the topical application or regional injection of a local anesthetic medication.

***ANALGESIA** - Results in the reduction of sensitivity to pain without loss of consciousness.

***CONSCIOUS SEDATION**- results in a minimally depressed level of consciousness that allows the patient to continually maintain an airway without assistance and respond quickly and appropriately to physical stimulation and verbal command. Protective reflexes are maintained. Conscious sedation can be achieved by oral (e.g. oral valium), inhalational (e.g. nitrous oxide), intramuscular or intravenous routes. Sedatives, narcotics and nitrous oxide are commonly intramuscular, or intravenous routes. Sedatives, narcotics, and nitrous oxide are commonly used drugs and are required in only low doses.

***DEEP SEDATION**- a controlled state of depressed level of consciousness accompanies by potential for partial or complete loss of protective reflexes, potential need for airway assistance, and diminished ability to respond appropriately to physical stimulation and/or verbal command. Deep sedation can be achieved by the same routes and drugs as conscious sedation using higher doses.

***GENERAL ANESTHESIA**- a controlled state of unconsciousness accompanied by loss of protective reflexes, inability to independently maintain an airway, and inability to purposefully respond to physical stimulation or verbal command. General anesthesia commonly involves combinations of intravenous sedatives, narcotics, and neuromuscular blockers along with inhaled "volatile anesthetics" and nitrous oxide. However general anesthesia may be induced simply by utilizing a large does of any of the medications used for sedation (for example, sodium thiopental or midazolam).

SUPPLEMENTAL CLAIM INFORMATION FORM

(Complete one form for each claim)

1. Name of applicant/named insured: _____
   _____
2. Name of other parties or defendants named in suit:_____
   _____
   _____
3. Data of alleged error or occurrence, or contact date:_____
4. Data claim was made: _____
5. Name of claimant: _____
6. Name of Insurance Company handling your claim: _____
7. Present status of claim or final disposition: _____
   _____
   _____
   Circle One: CLOSED OPEN
8. Defense costs paid to date inclusive of any deductible: _____
9. If closed, total loss paid, inclusive of any deductible: _____
10. If claim is open or pending, what are the insurers reserves?
    Defense: _____ Loss: _____
11. Description of case and events including allegations and assessment of liability: _____
    _____
    _____
    _____
    _____
    _____
12. Claimants last settlement demand:_____

_____ _____

Date Signature