Physicians Insurance
A MUTUAL COMPANY

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:
  - ☐ Interscalene
  - ☐ Axillary
  - ☐ Spinal
  - ☐ Supraclavicular
  - ☐ IV regional
  - ☐ Epidural
- ☐ Other: _____

22. Please indicate who provides sedation/analgesia/anesthesia at your facility:

- ☐ Surgeon
- ☐ RN
- ☐ Surgical Assistant
- ☐ CRNA
- ☐ Anesthesiologist
- ☐ 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.***