



**REQUESTED COVERAGE - AMBULATORY SURGERY CENTER APPLICATION**

**Requesting Professional Liability:**

Requested Retro Date: \_\_\_\_\_

**Professional Liability Limits**

**Professional Liability Deductible**

- |  |  |                                   |                                       |
|--|--|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> \$100,000 / \$300,000   | <input type="checkbox"/> \$1,000,000 / \$1,000,000 | <input type="checkbox"/> \$2,500  | <input type="checkbox"/> \$15,000     |
| <input type="checkbox"/> \$200,000 / \$600,000   | <input type="checkbox"/> \$1,000,000 / \$2,000,000 | <input type="checkbox"/> \$5,000  | <input type="checkbox"/> \$20,000     |
| <input type="checkbox"/> \$250,000 / \$750,000   | <input type="checkbox"/> \$1,000,000 / \$3,000,000 | <input type="checkbox"/> \$7,500  | <input type="checkbox"/> \$25,000     |
| <input type="checkbox"/> \$500,000 / \$1,500,000 | <input type="checkbox"/> Other: _____              | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> Other: _____ |

**Requesting General Liability:**

Requested Retro Date: \_\_\_\_\_ or  Occurrence Based Coverage

**General Liability Limits**

**General Liability Deductible**

- |  |  |                                   |                                       |
|--|--|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> \$100,000 / \$300,000   | <input type="checkbox"/> \$1,000,000 / \$1,000,000 | <input type="checkbox"/> \$2,500  | <input type="checkbox"/> \$15,000     |
| <input type="checkbox"/> \$200,000 / \$600,000   | <input type="checkbox"/> \$1,000,000 / \$2,000,000 | <input type="checkbox"/> \$5,000  | <input type="checkbox"/> \$20,000     |
| <input type="checkbox"/> \$250,000 / \$750,000   | <input type="checkbox"/> \$1,000,000 / \$3,000,000 | <input type="checkbox"/> \$7,500  | <input type="checkbox"/> \$25,000     |
| <input type="checkbox"/> \$500,000 / \$1,500,000 | <input type="checkbox"/> Other: _____              | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> Other: _____ |

**Requesting Employee Benefits Liability (supplement required):**

Requested Retro Date: \_\_\_\_\_

**Employee Benefits Liability Limits**

**Employee Benefits Liability Deductible**

- |  |  |                                  |                                   |
|--|--|----------------------------------|-----------------------------------|
| <input type="checkbox"/> \$100,000 / \$300,000   | <input type="checkbox"/> \$1,000,000 / \$1,000,000 | <input type="checkbox"/> \$1,000 | <input type="checkbox"/> \$10,000 |
| <input type="checkbox"/> \$200,000 / \$600,000   | <input type="checkbox"/> \$1,000,000 / \$2,000,000 | <input type="checkbox"/> \$2,500 | <input type="checkbox"/> \$15,000 |
| <input type="checkbox"/> \$250,000 / \$750,000   | <input type="checkbox"/> \$1,000,000 / \$3,000,000 | <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$20,000 |
| <input type="checkbox"/> \$500,000 / \$1,500,000 | <input type="checkbox"/> Other: _____              | <input type="checkbox"/> \$7,500 | <input type="checkbox"/> \$25,000 |

**Requesting Non-Owned Auto Liability (supplement required):**

**Non-Owned Auto Liability Limits**

- |                                    |                                       |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> \$100,000 | <input type="checkbox"/> \$500,000    |
| <input type="checkbox"/> \$200,000 | <input type="checkbox"/> \$1,000,000  |
| <input type="checkbox"/> \$250,000 | <input type="checkbox"/> Other: _____ |

\*Requested coverage may or may not be offered please review any quote issued for actual terms and conditions available. Completion of this application neither binds coverage nor guarantees that policy will be issued.





Kinsale Insurance Company  
 P. O. Box 17008  
 Richmond, VA 23226  
 (804) 289-1300  
[www.kinsaleins.com](http://www.kinsaleins.com)

### AMBULATORY SURGERY CENTER APPLICATION

Instructions to the Applicant – please complete this application in ink and answer all questions completely. Attach extra sheets as necessary should you run out of space provided. An incomplete or illegible application cannot be processed. Completion of this application neither binds coverage nor guarantees that a policy will be issued.

- Provide a fully completed application, signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
- If a question is not applicable, then state "N/A".
- The following information must be submitted with the completed application:
  - Copy of your current professional liability insurance Declarations Page (claims made policies must reflect the retroactive date)
  - Copy of all advertising that you use
  - 5-year company loss runs, valued within the last 60 days

#### GENERAL INFORMATION

1. Full name of Applicant (Including DBA's) \_\_\_\_\_

2. Mailing Address: \_\_\_\_\_  
STREET CITY COUNTY STATE ZIP

3. Location Address(es): Check here if same as mailing:

- (1) \_\_\_\_\_  
STREET CITY COUNTY STATE ZIP
- (2) \_\_\_\_\_  
STREET CITY COUNTY STATE ZIP
- (3) \_\_\_\_\_  
STREET CITY COUNTY STATE ZIP
- (4) \_\_\_\_\_  
STREET CITY COUNTY STATE ZIP

Attach Additional Pages as Needed

4. Website Address: [www.](http://www.) \_\_\_\_\_ 5. Telephone: \_\_\_\_\_

6. Inspection contact: \_\_\_\_\_

7. Date Established \_\_\_\_\_ Years under current management \_\_\_\_\_

8. Applicant is a:

- Individual
- Professional Associations
- Corporation
- Partnership
- LLC
- Joint Venture

Other: \_\_\_\_\_



9. Enterprise is:  For Profit  Not For Profit
10. Is this entity owned by, associated with or controlled by any other entity? Yes  No
- If yes, please provide details:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**APPLICANT'S PRACTICE**

11. What are the facility days and hours of operation? \_\_\_\_\_
12. Is the applicant accredited by or a member of any professional organization or association? Yes  No
- If yes, please name: \_\_\_\_\_
13. Estimated annual gross revenues in the next 12 months? \$ \_\_\_\_\_
- Annual gross revenues in the past 12 months? \$ \_\_\_\_\_
14. Does applicant maintain beds for overnight occupancy? Yes  No
- If yes, how many? \_\_\_\_\_ Also attach a copy of license and an explanation including protocols for onsite 24 hour staffing.
15. Please provide number of procedures for the following:

TYPE OF PROCEDURE	NUMBER PAST 12 MONTHS	ESTIMATED NUMBER NEXT 12 MONTHS
Abortions		
Bariatric Surgery		
Cosmetic Surgery		
Dental/ Oral Surgery		
Endoscopy/ Colonoscopy		
General Surgery		
Gynecological Surgery		
Manipulation under Anesthesia		
Obstetric		
Ophthalmology - Cataract		
Ophthalmology – Lasik / Refractive		
Orthopedic Surgery		
Orthopedic Surgery – Including Spine		
Otorhinolaryngology with Plastic		
Otorhinolaryngology no Plastic		
Pain Management		
Plastic/ Reconstructive Surgery		



Podiatry		
Radiological/ Nuclear/ Chemotherapy		
Other: (describe)		
Other: (describe)		

16. Any other services (other than surgery) not listed above? (i.e. Lab, Imaging, Office Visits, etc.) Yes  No   
 If yes, please list type and amount.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

17. **IF ABORTIONS** are indicated please complete the following otherwise skip to question 18.

	0-13 Weeks Gestation	13-16 Weeks Gestation	16-20 Weeks Gestation	20+ Weeks Gestation	Total
# of Surgical Abortions					
# of Medical Abortions					

- a. Does the applicant perform ultrasounds prior to **any** abortions? Yes  No   
 b. Please specify method(s) used for both Medical and Surgical Abortions:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

18. **IF BARIATRIC SURGERY** is indicated please complete the following otherwise skip to question 19.

- a. Please list all procedures and **attach** protocols for selecting and monitoring patients.  
 \_\_\_\_\_  
 \_\_\_\_\_
- b. Is Bariatric surgery **only** performed by American Board Certified General Surgeons? If no, on a separate page please describe which other surgical specialists are performing this procedure and the reasons why they have been granted privileges to perform this procedure ..... Yes  No
- c. Is this center a Bariatric Surgery Center of Excellence? ..... Yes  No

19. **IF PLASTIC OR COSMETIC SURGERY** is indicated please list all cosmetic procedures performed including botox or other injectables otherwise skip to question 20.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- a. If liposuction (any form or type) is indicated as being performed is it **only** performed by an American Board Certified Plastic Surgeon or General Surgeon? If no, on a separate page please describe which other surgical specialists are performing this procedure and the reasons why they have been granted privileges to perform this procedure. ....Yes  No

20. **IF PAIN MANAGEMENT** is indicated please list all Pain Management procedures performed otherwise skip to question 21

\_\_\_\_\_  
 \_\_\_\_\_

## POLICIES AND PROCEDURES

### 21. Policies and Procedures – Pre-operative:

Are written consent forms used for each type of procedure performed? If yes, Is the surgeon also required to sign the consent form? Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the physician required to discuss the procedure and consent with the patient prior to performing the procedure?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is there written documentation of a pre-operative anesthesia evaluation and airway assessment per ASA guidelines?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Preoperative history and physical examination in the medical record by the day of surgery?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is there a formal process in place which includes <b>pre-operative verification of the patient?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is there a formal process in place which includes <b>pre-operative verification of the surgical site?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is there a formal process in place to which includes <b>marking of the operative site?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is there a "time out" immediately before starting the procedure?	Yes <input type="checkbox"/> No <input type="checkbox"/>

### 22. Policies and Procedures – Intra and post-operative:

Is there documentation and signing of all intra-operative orders?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is there written documentation of all medications and intravenous fluids given?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are written post-operative instructions provided to all patients?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is there documentation and signing of all post-operative orders and timely dictation of operative notes?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is there a formal discharge policy requiring that a patient meet specific criteria prior to being discharged?	Yes <input type="checkbox"/> No <input type="checkbox"/>

### 23. Does the applicant have a preventative maintenance program for all biomedical equipment including anesthesia and critical emergency equipment that includes:

- a. Proper training of all equipment users? Yes  No
- b. Repairs by qualified personnel? Yes  No
- c. Documentation of all activities (preventive maintenance, repairs, education)? Yes  No

### 24. Anesthesia Delivery and Monitoring:

- a. What is the level of anesthesia provided?
  - Level A – Local or topical anesthesia
  - Level B – Local or topical anesthesia and/or IV or parenteral sedation, regional anesthesia, analgesia or dissociative drugs without the use of endotracheal or laryngeal mask intubation or inhalation general anesthesia
  - Level C – Levels listed above plus and/or surgical procedures with epidural anesthesia, endotracheal or laryngeal mask intubation or inhalation anesthesia, spinal or epidural
- b. Does the applicant permit professionals other than licensed Nurse Anesthetists and Anesthesiologists to administer and/or monitor sedation or general anesthesia? Yes  No
- c. Are non-Anesthesiologists administering Propofol or deep sedation? Yes  No

25. Is there a documented protocol for handling in house emergencies? Yes  No

26. Is there an agreement with a local hospital for emergency transfers? Yes  No



27. What is the distance from the applicant to the nearest acute care hospital? \_\_\_\_\_

**STAFF / CREDENTIALLED PROVIDERS**

28. Please provide the name and specialty of the applicant’s Medical Director \_\_\_\_\_

29. Does the applicant’s Medical Director have direct patient care? Yes  No

30. Is the applicant’s Medical Director  full-time or  part-time?

31. Please complete the staff / credentialed provider table below **AND** provide a staff listing by name for all credentialed physicians:

	<u>Number Employed?</u>		<u>Number Privileged</u>		Insured Elsewhere?	Coverage Desired?
	Full Time	Part Time	Full Time	Part Time		
Physicians: no surgery other than incision of boils and superficial abscesses; suturing of skin or superficial fascia					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Anesthesiologists; Pain Management Specialists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Dermatologist; Cardiologists; Gastroenterologist; Proctologists; Ophthalmologists; Urologists, Internists;					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
General Surgeons; Cardiac Surgeons;					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Obstetrics-Gynecologists, Plastic Surgeons, and Otolaryngologists doing plastic surgery					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Thoracic Surgeons; Vascular Surgeons; Neurosurgeons; and Orthopedic Surgeons					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Bariatric Surgeons					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Podiatrists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Dentists; Oral Surgeons					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Nurse Anesthetists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Physicians’ and Surgeons’ Assistants; Nurse Practitioners					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Perfusionists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pharmacists					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Chiropractors					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
RNs, LPNs					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
X-Ray Technician; Lab Technician					<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other (specify):						



32. Are all above individuals licensed in accordance with applicable state and federal regulations? Yes  No
33. Do you require all employed, contracted, or privileged physicians or nurse anesthetists to carry their own professional liability insurance? If yes, what limits are they required to carry? Yes  No
34. Does the Applicant have a formal credentialing and privileging process which includes primary source verification of professional credentials and privilege qualifications for all surgeons and anesthesia providers? Yes  No   
 If yes, does it include the following **AND attach copy of written credentialing protocols**:
- a. Review/approval of requested privileges by the center's medical director and/or credentials committee? Yes  No
  - b. Continuous updates of new or deleted privileges for ambulatory surgery center staff either through an automated or manual system? Yes  No
35. Can the Applicant's staff refuse to schedule a surgery or procedure that is not:
- a. On an individual provider's list of approved privileges? Yes  No
  - b. Authorized at the Applicant's surgical center? Yes  No

**PREMISES INFORMATION – complete only if you are requesting General Liability Coverage**

**Building Description**

	<u>Buildings/Wings</u>			
	#1	#2	#3	#4
Type of Construction:	_____	_____	_____	_____
No. of Stories:	_____	_____	_____	_____
Square Footage	_____	_____	_____	_____
Date Built:	_____	_____	_____	_____
Smoke detectors:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Local/Central station fire alarm:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sprinkler System:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial

36. Do any of the Applicant's locations have any (explain any "yes" answers on page 8):
- a. Exposure to flammables, explosive, chemicals?  YES  NO
  - b. Catastrophe exposure?  YES  NO
  - c. Exposure to radioactive materials?  YES  NO
37. Has any claim for General Liability **ever** been made against any person(s) or entity(ies) proposed for this insurance? If Yes, answer complete a supplemental claims form for each.  YES  NO
38. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which may result in a General Liability claim, such that would fall under the proposed insurance? If Yes, complete a supplemental claims form for each.  YES  NO



## COVERAGE HISTORY

39. Please list professional liability insurance carried for each of the past five years.

Insurer	Dates covered	Limits of Liability Per claim/ agg	Deductible	Premium	Retroactive date

40. If the applicant is currently insured under a commercial general liability policy please list coverage for the past five years.

Insurer	Dates covered	Limits of Liability Per claim/ agg	Deductible	Premium	Occurrence or Claims – Made?

If the current expiring GL policy is claims- made what is the retroactive date? \_\_\_\_\_

## CLAIMS AND HISTORY – Please explain or complete a supplemental claim form for all “Yes” answers

41. Has the applicant or any of its employees ever had any professional license or license to prescribe and or dispense narcotics ever been limited, suspended, revoked, denied, or investigated by any licensing board or regulatory agency? **Explain on page 9 or attach additional pages as needed**  YES  NO
42. Has the applicant or any of its employees ever been charged with, or convicted of a crime **other** than minor traffic violations? **Explain on page 9 or attach additional pages as needed**  YES  NO
43. Has the applicant or any of its employees ever been diagnosed or treated for alcoholism, drug addiction, any chemical dependency, or mental or chronic physical illness? **Explain on page 9 or attach additional pages as needed**  YES  NO
44. Has any claim or suit for malpractice or professional liability ever been made against the applicant **OR** any other person proposed for this insurance? **How Many?** \_\_\_\_\_ **(Complete Supplemental Claims form for Each)**  YES  NO
45. Is the Applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit? **If yes, please explain in detail, completing a supplemental claim form for each.**  YES  NO
46. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance that has not been reported to the Applicant’s current or prior insurer? **If yes, please explain in detail, completing a supplemental claim form for each.**  YES  NO







commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

**NOTICE TO OHIO APPLICANTS:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**NOTICE TO OKLAHOMA APPLICANTS: WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes a any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**NOTICE TO PENNSYLVANIA APPLICANTS:** Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of a claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

**NOTICE TO TENNESSEE APPLICANTS:** 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.

**NOTICE TO VIRGINIA APPLICANTS:** 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.

**The Applicant acknowledges that the answers provided herein are based on a reasonable inquiry and/or investigation. The Applicant warrants that the above statements and particulars together with any attached or appended documents are true and complete and do not misrepresent, misstate or omit any material facts.**

**The Applicant agrees to notify us of any material changes in the answers to the questions on this questionnaire which may arise prior to the effective date of any policy issued pursuant to this questionnaire and the Applicant understands that any outstanding quotations may be modified or withdrawn based upon such changes at our sole discretion. Completion of this form does not bind coverage. Applicant's acceptance of the company's quotation is required prior to binding coverage and policy issuance. All written statements and materials furnished to the company in conjunction with this application are hereby incorporated by reference into this application and made a part of this application.**

Applicant: \_\_\_\_\_ Title: \_\_\_\_\_

FEIN #: \_\_\_\_\_

Applicants Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Agent/Broker Name: \_\_\_\_\_



**SUPPLEMENTAL CLAIM / INCIDENT INFORMATION**

If reporting more than one claim or incident, please photocopy and complete a separate form for each. Attach additional sheets if necessary for adequate explanation. All questions must be answered or marked Not Applicable (N/A), and each sheet must be signed.

Name of Patient: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Incident  Claim

Date reported to insurance company: \_\_\_\_\_

Name of insurance company: \_\_\_\_\_

Date of incident and your treatment: \_\_\_\_\_

Allegations / Circumstances: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional Defendants: \_\_\_\_\_

What is the present condition of the patient? \_\_\_\_\_

\_\_\_\_\_

**STATUS OF CLAIM**

- Suit threatened, no action taken
- Suit filed but dropped by claimant
- Summary judgment in your favor

**Court outcome in YOUR favor:**

- Jury verdict
- Directed verdict

**Unresolved/Open**

- Awaiting mediation
- Awaiting court action

Reserve amount:  
\$ \_\_\_\_\_

- Suit settled out of court
  - a. Date claim paid: \_\_\_\_\_
  - b. Amount paid: \$ \_\_\_\_\_
  - c. Did you want to settle?
    - Yes  No

**Court outcome in favor of plaintiff:**

- Jury verdict
  - Directed verdict
- Amount of loss payment:  
\$ \_\_\_\_\_

Name and address of the attorney assigned to your case: \_\_\_\_\_

\_\_\_\_\_

To your knowledge, was any settlement paid by another party involved (i.e., your P.A., P.C., partners, employees, etc.)?

Yes:  No:

Explain in detail what action(s) you have taken to prevent recurrence of this type of claim:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

