

U.S. Risk, LLC | 8401 N. Central Expressway, Dallas, Texas 75225

MEDICAL STAFFING AND NURSE REGISTRY PROFESSIONAL AND GENERAL LIABILITY APPLICATION—CLAIMS MADE AND REPORTED BASIS

Please email this completed application to the U.S. Risk underwriter you are working with.

For contact information, please visit the [U.S. Risk HealthcarePros webpage](#).

Desired effective date: _____

1. Complete name of applicant (if other than parent firm, supply full details of ownership entity; attach an additional sheet if necessary):

Address: _____

City: _____ State: _____ County: _____ ZIP: _____

Contact Name: _____ Title: _____

Contact Email Address: _____ Phone: _____

Website URL: _____

List all other locations:

2. Applicant is:

a. Individual Partnership Corporation Professional Association Other: _____

b. Not-for-profit For-profit Both

3. Date established: _____

4. a. Type of firm: Medical staffing Nurse registry Other (explain): _____

b. Total annual gross revenues: \$ _____

5. Is the firm engaged in, owned by or associated with or controlled by any other business? Yes No

If yes, provide details (use an additional sheet of paper if necessary):

6. Does the applicant own (wholly or in part), operate or administer any other business or other institution where medical services are customarily rendered? Yes No

If yes, provide details:

7. List the individual partners or members of the applicant who provide professional services:

8. Are any services provided outside of the United States? Yes No

If yes, explain, including what countries, what type of services are provided and what percentage of your revenues are derived from these services:

9. Do you provide any internet services? Yes No

If yes, please attach an explanation, including confirmation of licensing in all states in which services are provided.

10. Does the applicant anticipate any expansions within the next year? Yes No

If yes, please describe:

11. Does the applicant advertise its professional services in any manner (other than a simple listing in a telephone directory)? Yes No

If yes, please attach a copies of **all** advertisements.

12. Does the applicant participate in any activity, e.g. newspaper columns, broadcasts, etc., whereby professional advise is offered to the public?

Yes No

13. Hold Harmless (Indemnification) Agreements:

a. **In favor of the applicant:** If the applicant has obtained any written indemnification agreements holding the applicant harmless, please describe and indicate if certificates of insurance are obtained:

b. **In favor of others:** Has the applicant agreed to indemnity (hold harmless) others under written contract? Yes No

If yes, please submit a copy of the agreement.

14. Is the applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? Yes No

If yes,

a. Has the applicant implemented procedures to comply with the HIPAA Privacy Rule? Yes No

b. Name and title of the applicant's privacy officer: _____

15. Do you have any contracts with any of the following?

a. Hospitals? Yes No

If yes, what is the percentage of total revenues from this contract? _____ %

b. Nursing Homes? Yes No

If yes, what is the percentage of total revenues from this contract? _____ %

c. Other Entities? Yes No

If yes, what is the percentage of total revenues from this contract? _____ %

Describe:

16. Location and percentage where services are provided (**total must equal 100%**):

Location	Percentage
Private home	_____ %
Assisted living	_____ %
Hospital	_____ %
Clinic/physicians office	_____ %
Nursing home	_____ %
Hospice	_____ %
Adult daycare	_____ %
Other (specify):	_____ %



17. Type of services provided along with the percentage (**total must equal 100%**):

Services	Percentage
Skilled Nursing Care	_____ %
Emergency, Urgent Care or Surgery (if a percentage, provide details): _____	_____ %
Personal Care Chore or Companion	_____ %
Physical/Occupational/Speech Therapy	_____ %
Infusion Therapy	_____ %
Complete pediatric care (percentage of persons under age 18)	_____ %

18. Schedule of all employees and independent contractors:

Discipline	Employees			Independent Contractors	
	Number of Full-Time	Number of Part-Time	Annual Hours Worked	Number of Contractors	Annual Hours Worked
Administrator	_____	_____	_____	_____	_____
Physician	_____	_____	_____	_____	_____
Psychiatrist	_____	_____	_____	_____	_____
Psychologist—Doctorate	_____	_____	_____	_____	_____
Psychologist—Bachelors/Masters	_____	_____	_____	_____	_____
Counselor—Other	_____	_____	_____	_____	_____
Social and Case Workers	_____	_____	_____	_____	_____
Occupational Therapist	_____	_____	_____	_____	_____
Respiratory Therapist	_____	_____	_____	_____	_____
Physical Therapist	_____	_____	_____	_____	_____
Speech Therapist	_____	_____	_____	_____	_____
Therapist Aide	_____	_____	_____	_____	_____
Nurse—RN	_____	_____	_____	_____	_____
Nurse—LPN/LVN	_____	_____	_____	_____	_____
Nurse Practitioner	_____	_____	_____	_____	_____
Nurse Aide	_____	_____	_____	_____	_____
Home Health Aide	_____	_____	_____	_____	_____
Pharmacist	_____	_____	_____	_____	_____
Pharmacy Assistant	_____	_____	_____	_____	_____
General Clerical or Maintenance	_____	_____	_____	_____	_____
Medical Technician	_____	_____	_____	_____	_____
Homemaker/Provider/Caregiver	_____	_____	_____	_____	_____
Other (specify): _____	_____	_____	_____	_____	_____



- a. Do aides and/or homemakers have CPR or First Aid Training? Yes No
- b. Are all the above individuals licensed in accordance with applicable state and federal regulations? Yes No

If no, attach an explanation.

- c. Is continuing education or staff development required for your employees? Yes No
- d. If you use subcontractors, do subcontractors carry their own coverage? Yes No

If yes, are limits of coverage equal to or greater than your limits? Yes No

19. HIRING PRACTICES

- a. Do you require signed applications on all prospective employees? Yes No
- b. Does your staff employment application include questions about whether the individual has ever been convicted of any crime, including sex-related or child-abuse-related offenses? Yes No
- c. Do you verify all professional qualifications, licenses and certifications at time of employment? Yes No
- d. Do you regularly check employees' licenses and certifications? Yes No
- e. Do you conduct a personal interview with prospective employees and non-employees? Yes No
- f. Do you require professional and personal references on each employee? Yes No
- g. Do you conduct a criminal background check? Yes No
- h. Do you require drug/alcohol screening? Yes No
- i. Do you provide training and orientation for new employees? Yes No
- j. Do you follow up on any pending license suspensions or revocations or any pending disciplinary actions? Yes No
- k. Do you ask if there have been any professional liability or work-related claims made against the applicant in the past? Yes No

20. RISK MANAGEMENT/LOSS CONTROL

- a. Is there a written, formalized Risk Management Program? Yes No
- b. Is there a written, formalized Quality Assurance Program? Yes No
- c. In case of an emergency, is management available 7 days a week, 24 hours a day? Yes No
- d. Do you discuss at staff orientation elder and/or child abuse or sexual abuse? Yes No
- e. Do you have a supervision plan in place that monitors staff in the daily relationships with clients? Yes No

21. GENERAL LIABILITY

Complete the following for any owned or leased premises (use a separate sheet of paper if needed):

Location Address	Occupancy	Percentage
<hr/>	<input type="checkbox"/> Owned <input type="checkbox"/> Leased	<hr/> %
<hr/>	<input type="checkbox"/> Owned <input type="checkbox"/> Leased	<hr/> %

Are you required to name your landlord or any other business as an additional insured? Yes No

If yes, please list name and address of each and state interest. Use separate sheet if required:

Name	Address	Interest
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

22. DURABLE MEDICAL EQUIPMENT

- a. Do you supply or sell any medical supplies or equipment to patients or clients? Yes No
 b. Do you rent or lease or supply any medical or therapeutic equipment to patients or clients? Yes No

If yes, please complete the following:

Category I	Expendable Items (intended for one time use and then disposed of)	Annual Sales: \$ _____
Category II	Non-expendable Items (including hospital beds, bathroom safety bars, portable toilets, lifts or hoists, ambulatory aids; excludes diagnostic treatment equipment devices)	Annual Sales: \$ _____
		Annual Rental Receipts: \$ _____
Category III	Diagnostic or Treatment Devices (including oxygen and other medical gasses used in conjunction with respiratory therapy; excluding ventilators)	Annual Sales: \$ _____
		Annual Rental Receipts: \$ _____
Category IV	Life Sustaining or Critical Monitoring Equipment or Devices (including dialysis or heart/lung machines, all monitors)	Annual Sales: \$ _____

23. EXISTING INSURANCE

Do you currently carry the following:

- a. Professional Liability Insurance? Yes No

If yes, list the Professional Liability Insurance carried by the firm for each of the past five years including periods of no coverage:

Policy Period FROM MM/DD/YY	Policy Period TO MM/DD/YY	Insurance Company	Limit of Liability	Deductible	Policy Form: Claims Made OR Occurrence?	Premium
_____	_____	_____	\$ _____	\$ _____	_____	\$ _____
_____	_____	_____	\$ _____	\$ _____	_____	\$ _____
_____	_____	_____	\$ _____	\$ _____	_____	\$ _____
_____	_____	_____	\$ _____	\$ _____	_____	\$ _____
_____	_____	_____	\$ _____	\$ _____	_____	\$ _____

If claims made, what is the retroactive date/prior acts date on your current policy? _____

- b. Commercial General Liability Insurance? Yes No

If yes, list the Commercial General Liability Insurance currently carried by the firm:

Policy Period	Carrier	Limit of Liability BI/PD	Deductible	Policy Form: Claims Made OR Occurrence?	Premium
_____	_____	\$ _____	\$ _____	_____	\$ _____

If claims made, what is the retroactive date/prior acts date on your current policy? _____

24. CLAIMS HISTORY

- a. During the past five (5) years, have there been any professional or general liability claims or incidents made against you, any employee or former employee, the applicant or anyone proposed for this insurance? Yes No

ATTACH CURRENTLY VALUED COMPANY LOSS RUNS FOR THE PRIOR FIVE (5) YEARS.

- b. Are you, or anyone proposed for this insurance aware of any fact(s), incident(s), act(s), event(s), circumstance(s) or occurrence(s) that may result in a claim(s) being made against you? Yes No

If yes, provide full details:

- c. Have there been any prior complaints or incidents reported arising out of alleged or actual physical or sexual abuse or molestation?

Yes No

If yes, fully describe the circumstances and follow-up action taken:

APPLICANT SIGNATURE PANEL

THE APPLICANT DECLARES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE INCEPTION DATE OF THE POLICY PERIOD, WILL IMMEDIATELY NOTIFY THE UNDERWRITERS OF SUCH CHANGE. SIGNING OF THIS APPLICATION DOES NOT BIND THE UNDERWRITERS TO OFFER, NOR THE APPLICANT TO ACCEPT INSURANCE; BUT IT IS AGREED THAT THIS APPLICATION SHALL BE THE BASIS OF THE INSURANCE AND MADE A PART OF THE POLICY SHOULD A POLICY BE ISSUED.

APPLICABLE IN THE STATE OF NEW YORK: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONTAINING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Notice applicable in most states: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance, or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

I/We hereby declare that the above statements and particulars are true and I/we agree that this application shall be the basis of the contract with the insurance company.

Authorized signature

Date

Typed or printed name: _____

Title: _____