LEXINGTON INSURANCE COMPANY
ADMINISTRATIVE OFFICE: 100 Summer Street, Boston, MA 02110

(Each of the above being a capital stock company)

MEDICAL PROFESSIONAL LIABILITY INSURANCE
MEDICAL GROUP PRACTICE

APPLICATION

Please review this application carefully and discuss it with your insurance representative. If a policy is issued, the application will become part of the policy as if physically attached. Therefore, it is necessary that all questions be answered accurately and completely.

Instructions:

1. PLEASE PRINT OR USE MICROSOFT WORD TO TYPE TEXT DIRECTLY ONTO THE APPLICATION.
2. ANSWER ALL QUESTIONS LEAVING NO BLANKS.
3. IF ANY QUESTIONS, OR PART THEREOF, DO NOT APPLY, STATE N/A IN THE SPACE.
4. THIS APPLICATION MUST BE COMPLETED, DATED AND SIGNED BY THE MEDICAL GROUP APPLYING FOR COVERAGE.
5. WHEN NECESSARY, CHECK ALL BOXES THAT APPLY.

Please attach and make a part of this application by referencing the following:

1. ☐ Copy of last ten years (or back to retro date whichever is longer) currently valued, first-dollar loss experience including paid and reserved losses. Provide complete details (occurrence date, claims made date, description of occurrence, and all codefendants) for any loss paid or reserved.

2. ☐ If available, latest two years of audited financial statements, including balance sheets and income statements; copy of interim report if audited statement is over six months.

3. ☐ Copy of any applicable self-insurance trust agreement, trust financials and most recent actuarial studies.

4. ☐ Completed Physician Addendum (see page 10) and Allied Healthcare Provider Addendum (see page 12) or a roster (preferably in electronic format) that includes all of the information requested on pages 10 and 12.

5. ☐ Copies of Certificates of Insurance for all physicians and allied healthcare providers for whom coverage is not being requested.

SECTION I

1. GENERAL INFORMATION

Name of Medical Group:

Date of Group Establishment: _____ Employers Federal Tax ID #: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____ Website Address: _____

Practice Administrator Name/Title: _____

Practice Administrator Fax: _____ Practice Administrator Telephone: _____

Practice Administrator E-Mail Address _____

2. COVERAGE INFORMATION

Coverage Requested New Applicant ☐ Renewal ☐

a. Requested Policy Period: Effective Date: _____ Expiration Date: _____

b. Requested Retroactive Date(s): Primary: _____ Excess: _____
(Date first continuously insured under a claims-made policy.) Please attach verification of current retroactive date(s); (i.e., copy of current policy or declarations page).

c. **Select Requested Limits of Liability**: (Each Medical Incident or Event / Annual Aggregate for all Medical Incidents and Events)

☐ $1,000,000 / $3,000,000 ☐ $2,000,000 / $4,000,000 ☐ other: $_____ / $_____

Will defense/expense be within policy limits? Yes ☐ No ☐

d. **Select Limit Application**:

☐ Separate limit for General Liability
☐ Separate limit for the Medical Group Entity
☐ Individual limits for each insured physician
☐ Shared limit basis (Medical Group Entity and all insured physicians/ allied healthcare providers share in the limits)
☐ Excess Shared limit basis (Medical Group Entity and all insured physicians/ allied healthcare providers share in the limits)

e. **Select Deductible or Self Insured Retention Amount**:

☐ Deductible: ☐ Self Insured Retention
(Each Medical Incident or Event)

☐ $ 25,000 ☐ $ 50,000 ☐ $100,000 ☐ Other: $_____
(Deductible may require Chartis approved Letter of Credit. Self insured retention may require Chartis approved TPA.)

f. **SIR Accounts**:

1. To what line(s) of coverage will the SIR apply? _____
2. What are the limits of liability for the SIR? $_____ per occurrence, $_____ aggregate.
3. Are loss adjustment expenses part of ☐ or outside ☐ the SIR limit?
4. Is there a dedicated trust? ☐ Yes ☐ No.
If yes, what financial institution manages the trust? _____

If not, is there a captive? ☐ Yes ☐ No.
Details: _____
5. Has an independent actuarial review been completed? ☐ Yes ☐ No
If yes, please attach most recent study

g. **Claims Management**:

1. Who, within the organization, is responsible for claims management activities?
Name: _____ Title: _____ Phone Number: _____
2. Do you have written claims management procedures: Yes ☐, please attach. No ☐
3. Does a Third Party Administrator manage claims within the SIR? Yes ☐ No ☐
If yes, please provide name of TPA Firm and Contact: _____Phone Number: _____

h. **Excess Coverage**: Please complete the following if excess coverage is desired.

1. Please list underlying coverage over which excess coverage is to apply and attach copy of current policy Declarations page for each coverage.

	Carrier	Policy Number	Effective Date	Limits of Liability
Professional Liability				
General Liability				
Employers Liability				
Automobile Liability				
Ambulance Liability				
Non-owned Aircraft Liability				
Non- Owned Watercraft Liability				
Other Liability (Specify)				

2. Please include the number and description of use of any owned, leased or chartered:
(passenger cars, trucks, patient transport vehicles, and ambulances)

_____

_____

3. State your loss record during the past 5 years:
(passenger cars, trucks, patient transport vehicles, and ambulances)

_____

_____

MEDICAL PROFESSIONAL LIABILITY INSURANCE COVERAGE (FOR PREVIOUS FIVE YEAR PERIOD)

Prior Coverage: Please provide coverage history.

	Current Year	First Prior Year	Second Prior Year	Third Prior Year	Fourth Prior Year	Firth Prior Year
Insurance Company						
Policy Number						
Limits of Liability						
Deductible or SIR Amount						
Coverage Form (Occurrence/Claims Made)						
Retroactive Date						
Policy Period						
Premium						

SECTION II

UNDERWRITING INFORMATION

A. **Group Practice Information**

1. a. Please select type of ownership:
   - ☐ Business Corporation
   - ☐ Limited Liability Company
   - ☐ Not for profit corporation/foundation
   - ☐ Partnership
   - ☐ Professional corporation/association
   - ☐ Sole proprietorship
   - ☐ Other _____.

   b. Please describe the majority owner of your practice_____.
   (i.e. Physicians, Physicians Practice Management Company, Hospital, University or medical school, other)

2. Does the medical group own (wholly or in part), operate, or manage any business not engaged in rendering health care services? ☐ Yes ☐ No
If yes, please provide name(s) of entity/entities and description of business:

_____

_____

a. If yes, have any of these entities operated under other names? ☐ Yes ☐ No
If yes, please provide name(s) of entity/entities:

_____

3. Within the next 12 month period, does the medical group plan to:
(Please explain all "Yes" answers on the attached Remarks Addendum (page 13)).
a. Acquire another medical group/entity? ☐ Yes ☐ No
b. Add to or decrease the number of physicians? ☐ Yes ☐ No
c. Expand or reduce the number of locations? ☐ Yes ☐ No

4. Number of projected (next 12 months) full time equivalent (FTE) Physicians _____FTEs.

Number of employed MDs _____number of contracted MDs_____

Physicians	Current Year	First Prior Year	Second Prior Year	Third Prior Year	Fourth Prior Year	Fifth Prior Year
Historical # of FTEs						

(Please complete Physician Addendum (page 10)).

5. Number of projected (next 12 months) full time equivalent (FTE) Allied Health and Mid-level providers _____ FTEs.

Number of Allied Health employees _____number of Allied Health contractors_____

Allied Health and Mid-level Providers	Current Year	First Prior Year	Second Prior Year	Third Prior Year	Fourth Prior Year	Fifth Prior Year
Historical # of FTEs						

(Please complete Allied Healthcare Provider Addendum (page 11))

6. Has the medical group, any of its member practitioners, or any employees:
(Please explain all "Yes" answers on the attached Remarks Addendum (page 13)).
a. Ever been the subject of disciplinary of investigative proceedings or 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 other chemical dependency? ☐ Yes ☐ No
d. Ever had any state professional license or license to prescribe or dispense narcotics refused, reduced, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? ☐ Yes ☐ No
e. Ever had privileges reduced, suspended or revoked? ☐ Yes ☐ No
f. Ever been denied a license or certification to practice? ☐ Yes ☐ No
g.Ever had any state professional license or license to prescribe or dispense narcotics refused, reduced, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same ☐ Yes ☐ No
h.Ever had privileges reduced, suspended or revoked? ☐ Yes ☐ No
i. Ever been denied a license or certification to practice? ☐ Yes ☐ No
j. Ever had Medicare or Medicaid authorities ever initiated and investigation for alleged billing fraud and abuse?
☐ Yes ☐ No

7. Is your organization accredited by a national organization? If yes, which accrediting body? (check all that apply)
☐ American Association of Accredited Ambulatory Surgery Facilities (AAAASF)
☐ Accrediting Association for Ambulatory Health Care (AAAHC)
☐ Joint Commission
☐ National Committee for Quality Assurance (NCQA)
☐ Other_____.

8. Are you a member of a national organization?
☐ MGMA ☐ Other _____.

9. Does the medical group advertise? ☐ Yes ☐ No
(Please enclose copies of any printed advertising materials used to promote practice.)

B. **Radiology**:

1. Does the medical group operate a radiology center? ☐ Yes ☐ No
If yes, please indicate number of services and annual procedures:
☐ Diagnostic services _____ current annual reads/studies _____ next 12 month projection.
☐ Therapeutic services _____ annual procedures _____ next 12 month projection.

C. **Surgi Center**:

1. Does the medical group operate a Surgi-center? ☐ Yes ☐ No
If yes, please indicate number of surgeries performed during:
The past 12 month period _____ projected next 12 month period _____
2. Does the medical group maintain any beds for overnight occupancy? ☐ Yes ☐ No
3. What is the distance to the nearest hospital?_____
4. What equipment is available in the event of an emergency?_____

E. **Urgent Care**:

1. Does the medical group operate as an urgent care clinic? ☐ Yes ☐ No
If yes, please provide the number of patient visits over the past 12 month period _____.
Projected patient visits for the next 12 months _____.

F. **Pharmacy**:

1. Does the medical group operate a pharmacy? ☐ Yes ☐ No
2. If a pharmacy is operated by the medical group, is coverage for Druggist Liability desired? ☐ Yes ☐ No
If yes, indicate annual receipts for the pharmacy: _____
3. Is the pharmacy for patient use only? ☐ Yes ☐ No
4. Does the medical group contract with a pharmacy? ☐ Yes ☐ No
5. If a contract group, does the group furnish mutual hold harmless agreements? ☐ Yes ☐ No

G. **Bariatric Surgeons**:

1. Number of Bariatric procedures projected in the next 12 months _____.

	First Prior Year	Second Prior Year	Third Prior Year	Fourth Prior Year	Fifth Prior Year
Number of Bariatric Procedures					

2. Does the Bariatric program provide the following?
a. Pulmonary, cardiac, nutritional and psychological consultants; ☐ Yes ☐ No
b. Office support for preoperative and postoperative counseling: ☐ Yes ☐ No
c. Support groups; ☐ Yes ☐ No
d. Monitor and manage short-term and long-term complications; ☐ Yes ☐ No
e. Is the program certified; ☐ Yes ☐ No
If yes by whom _____.

H. **Managed Care**:

1. Please provide names of all Managed Care organizations the medical group contracts with:
_____
_____

2. Is the medical group responsible for services such as peer review, quality assurance, utilization review, and credentialing, and/or health care management on behalf of the MCO? ☐ Yes ☐ No

a. If yes, do these Managed Care Organizations provide errors and omissions coverage for these activities?
☐ Yes ☐ No

3. Does you medical group operate or own any health plans? ☐ Yes ☐ No
a. If yes, is coverage desired for health plan? ☐ Yes ☐ No
b. If yes, please indicate number of lives_____

l. **Clinical Trials:**

1. Is the medical group involved in clinical trials? ☐ Yes ☐ No

SECTION III

CLAIMS HISTORY

1. Please provide hard copy carrier loss runs and, when available, in electronic format:
a. Ten years of historical PL and GL losses including current year, ground-up and unlimited, including all self insured, insured, and uninsured losses.
b. Date of loss valuation must be within past ninety days.
c. Lost run must include: carrier, claimant name, date of loss, report date, indemnity paid, indemnity reserved, expenses paid, expenses reserved, total incurred, status (open of closed), type (PL or GL), and narrative of claim.
d. Full details of allegations on all losses paid or outstanding in excess of $50,000 even if greater than 10 years old. (Please provide details on the attached Remarks Addendum (page 13)).

THE APPLICANT REPRESENTS THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN SUPPRESSED OR MISSTATED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED BEFORE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE HOSPITAL AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE HOSPITAL UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.

NOTICE TO APPLICANTS: 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 FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.

NOTICE TO ILLINOIS APPLICANTS: THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF MATERIAL FACT IN THE POLICY WILL RENDER THIS POLICY, IF ISSUED, VOID AT INCEPTION. THE DISCOVERY OF ANY FRAUD, INTENTIONAL CONCEALMENT, OR MISREPRESENTATION OF A MATERIAL FACT DURING A CLAIM WILL RENDER THIS POLICY, IF ISSUED, CANCELLED.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.

NOTICE TO LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MAINE 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 MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: 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 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 TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE 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 ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO OREGON APPLICANTS: 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 FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

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 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 SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON 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 VERMONT APPLICANTS: 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 FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Signature of Applicant:
(Must be an officer or principal of the Insured)

Print Name: _____

Title: _____

Date: _____

Signature of Producer: _____

Print Name: _____

Company: _____

License #: _____

Date: _____

NJ SLA# (if a NJ Risk): _____

Broker responsible for Surplus Lines Filings Agreement: _____

SCHEDULE OF RELATED ENTITIES: SUBSIDIARIES/JOINT VENTURES/LIMITED LIABILITY COMPANIES/PARTNERSHIPS
(If available, the information being requested may be provided by attachment of an organizational listing)

Name	Type of Business Description of Operations	Date Created, Acquired or Merged	% of Ownership by Applicant	Names of Other Owners and % of Ownership	Insurance Coverage Desired for this Entity? Yes / No	If Yes, Desired Retroactive Date

Physician Addendum
(If available, it is preferable that the information being requested on this form be provided in an electronic format)
Include only those contracted or employed providers for whom coverage is to be provided under this policy.

Name of Physician (Last, First, Middle) Indicate MD or DO	State(s) Where Licensed to Practice	*PCF Eligible Y/N	Board Cert'd Y/N	Initial Date in Practice	** Specialty-Surgery (Major, Minor, None) and Sub-specialty, if applicable	Contract/Employed/Resident/ Shareholder/ Partner/Officer of Corporation	Avg. No. Hrs/Wk	Retroactive Date

*If the physician practices in Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, South Carolina, or Wisconsin, please indicate "Yes" or "No" for Eligible for the
State's Patient Compensation Fund

**Surgery:
No Surgery-- Incision of boils and superficial abscesses, suturing of skin, and superficial fascia, any similar minor procedures encountered in a normal family type practice shall be considered "No Surgery." This includes administration of local and topical anesthesia.
Minor Surgery-- Includes above and assisting in major surgery on your own patients. Administration of anesthesia limited to topical and local.
Major Surgery-- Includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis, or any other operation which because of the condition of the patient or the length or circumstances of the operation presents a distinct hazard to life. It also includes: removal of tumors, open bone fractures

Departed Physicians

List the physicians who have previously practiced with the entity and have left within the past (5) years. Also indicate whether that individual currently has a claim or incident pending.

Name	Specialty	Practiced with Entity From Month/Day/Year	To Month/Day/Year	Tail Coverage Secured Individual	Entity	Claim or Incident
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐
				☐	☐	☐

*If the physician practices in Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, South Carolina, or Wisconsin, please indicate “Yes” or “No” for Eligible for the
State’s Patient Compensation Fund

**Surgery:
No Surgery--Incision of boils and superficial abscesses, suturing of skin, and superficial fascia, any similar minor procedures encountered in a normal family type practice shall be considered “No Surgery.” This includes administration of local and topical anesthesia.
Minor Surgery--Includes above and assisting in major surgery on your own patients. Administration of anesthesia limited to topical and local.
Major Surgery--Includes operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis, or any other operation which because of the condition of the patient or the length or circumstances of the operation presents a distinct hazard to life. It also includes: removal of tumors, open bone fractures

ALLIED HEALTHCARE AND MID-LEVEL PROVIDER ADDENDUM
(If available, it is preferable that the information being requested on this form be provided in an electronic format)

*ALLIED HEALTHCARE PROVIDERS AND MID-LEVEL PROVIDERS are defined as: Chiropractor; Heart/lung perfusionist; Nurse Anesthetist; Nurse Midwife (no delivery); Nurse Midwife (with delivery); Nurse practitioner; Optometrist; Physician assistant; Physiotherapist; Psychologist; Radiological technician who provides radiation therapy; Surgeon assistant)

Include only those contracted or employed providers for whom coverage is to be provided under this policy.

Names of Allied Healthcare Providers (Last, First, Middle)	State(s) Where Licensed	*Classification	Contracted or Employed	Retroactive Date Desired

Please use this addendum for any additional remarks or explanations associated with the application. Indicate the question number to which you are referring in the space provided.

Question	Remark / Explanation:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
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Emergency Department Physician Group Risk Assessment

Name of Applicant: _____

Corporate Address: _____
City: _____
State: _____

This addendum is supplemental to the general application incorporated by reference and with this policy issued in reliance therein.

S1 - Organization and Structure

Q1.1 (1.4) - Are there formal administrative policies and procedures in place for the management of the group?

- ☐ Yes
- ☐ No

Q1.2 (1.5) - Does the group have a leadership team that sets policy and procedure, and conducts oversight?

- ☐ Yes
- ☐ No

Q1.3 (1.6) - Does the group have a designated representative who participates, on at least an *ad hoc* basis, in the following committees *at each hospital whose ED is staffed by the group* (select all that apply)?

- ☐ Risk/Claims Management Committee
- ☐ Quality/Performance Improvement Committee
- ☐ Credentialing Committee
- ☐ Patient Safety Committee
- ☐ Emergency Department Committee
- ☐ Products Standards/Products Evaluation Committee
- ☐ Pharmacy and Therapeutics Committee

Q1.4 (1.7) - Do *any* of the group's physicians in *any* of the EDs for which your group provides staffing write admitting orders?

- ☐ Yes
- ☐ No, but hold orders are written
- ☐ No
- ☐ Unknown

Q1.5 (1.8) - Do *any* of the group's physicians routinely write orders for tests to be performed after the conclusion of the episode of care in the ED (for example, due to unavailability of staff to perform the test)?

- ☐ Yes
- ☐ No
- ☐ Unknown

S1.6 (1.9) - Medical Director

Q1.6.1 (1.9.1) - Does the group employ physicians to act as medical directors *for each of the hospitals whose ED is staffed by the group*?
If you answer no, please go to S2 – Hiring, Credentialing and Recredentialing.

- ☐ Yes
- ☐ No

Q1.6.2 (1.9.2) **– Is the performance of each medical director evaluated on at least an annual basis?**

- ☐ Yes
- ☐ No

S2 – Hiring, Credentialing and Recredentialing

Q2.1 – Do you have a formal application process for physicians?

- ☐ Yes
- ☐ No

Q2.2 – Do you conduct a criminal background check in all states of previous residence for all applicants?

- ☐ Yes
- ☐ No

Q2.3 – Is the credentialing process for physician members delegated to the hospital for any of the EDs staffed by the group? Select no if the group conducts credentialing for its physician members and has not delegated this function to the hospital.

- ☐ Yes
- ☐ No

Q2.4 – If you answered *yes* to Q2.3, does the medical director or other member physician at each of the hospitals whose ED is staffed by the group *participate* in the credentialing process for physician members? If you answered *no* to Q2.3, select not applicable.

- ☐ Yes
- ☐ No
- ☐ Not Applicable

Q2.5 – If you answered *no* to Q2.3, do you have a formal credentialing process for application to the group? If you answered *yes* to Q2.3, select not applicable.

- ☐ Yes
- ☐ No
- ☐ Not Applicable

Q2.6 – Which of the following are verified with the primary source (select all that apply)? If you answered *no* or *not applicable* to Q2.5, select not applicable.

- ☐ Graduation from medical school
- ☐ Internship/residency/fellowship
- ☐ Specialty board certification
- ☐ Work history (all hospitals at which privileges have been held)
- ☐ Experience
- ☐ Current state licensure(s)
- ☐ Sanctions/limitations on license to practice
- ☐ Medical malpractice insurance coverage
- ☐ National Practitioners Data Bank
- ☐ Drug Enforcement Agency certificate
- ☐ CMS Office of Inspector General sanctions
- ☐ Not Applicable

Emergency Department Physician Group Risk Assessment

Q2.7 - Do you require specialty board certification (in any specialty) for all physician members of your group? "Board eligible" does not equate to yes.

☐ Yes

☐ No

Q2.8 - Do you require board certification in emergency medicine for all physician members of the group? "Board eligible" does not equate to yes.

☐ Yes

☐ No

Q2.9 - If you answered *no* to Q2.8, what percentage of the physician members of your group *are* board certified in emergency medicine? If you answered *yes* to Q2.8, select not applicable.

☐ More than 60 percent

☐ 25 to 59 percent

☐ Less than 25 percent

☐ Not Applicable

Q2.10 - If you answered *no* to Q2.8, which of the following certifications do you require for the physician members of the group who are not board certified in emergency medicine? If you answered *yes* to Q2.8, select not applicable.

☐ Advanced Cardiac Life Support (ACLS)

☐ Pediatric Advanced Life Support (PALS)

☐ Advanced Trauma Life Support (ATLS)

☐ Not Applicable

Q2.11 - Do you have written policies and procedures for identifying and managing disruptive physician members of the group?

☐ Yes

☐ No

Q2.12 - Do you have written policies and procedures for identifying and managing impaired physician members of the group?

☐ Yes

☐ No

Q2.13 - Do you have written policies and procedures that allow for drug testing of physician members of the group?

☐ Yes

☐ No

Q2.14 - Does your group require that a new physician undergo orientation to the group and to the ED(s)?

☐ Yes

☐ No

Q2.15 - Does *each* physician (including locum tenens physician), nurse practitioner (if applicable) and physician assistant (if applicable) have a specific delineation of privileges?

☐ Yes

☐ No

Q2.16 - Does your group perform recredentialing and privileging at least every three years for each member physician?

- ☐ Yes
- ☐ No

Q2.17 - Which of the following indicators of performance are used in determining whether to continue to grant credentials and privileges to member physicians (select all that apply)?

- ☐ Complaints from patients
- ☐ Incidents of disruptive behavior
- ☐ Returns to the ED within pre-set time period
- ☐ Returns to the ED within pre-set time period resulting in admission
- ☐ Unanticipated deaths within pre-set time period following ED visit
- ☐ Door to doctor time
- ☐ Complaints from staff/colleagues

Q2.18 - If a physician, nurse practitioner or physician assistant is terminated from the group for reasons related to the quality of care that that individual provided, would a report be made to the state medical board or other regulatory body?

- ☐ Yes
- ☐ No

S2.19 - Nurse Practitioners and Physician Assistants

Q2.19.1 - Does your group use nurse practitioners and/or physician assistants in any of the EDs staffed by the group?
If you answer no, please go to S2.20 – Locum Tenens.

- ☐ Yes
- ☐ No

Q2.19.2 - Is the credentialing process for nurse practitioners and/or physician assistants delegated to the hospital for any of the EDs staffed by the group? Select no if the group conducts credentialing for its nurse practitioners and/or physician assistants and has not delegated this function to the hospital.

- ☐ Yes
- ☐ No

Q2.19.3 - If you answered *yes* to Q2.19.2, does the group's medical director or other member physician at each of the hospitals whose ED is staffed by the group *participate* in the credentialing process for nurse practitioners and/or physician assistants who are employed by or who are members of the group? If you answered *no* to Q2.19.2, select not applicable.

- ☐ Yes
- ☐ No
- ☐ Not Applicable

Q2.19.4 - If you answered no to Q2.19.2, do nurse practitioners and/or physician assistants have a formal credentialing process as members/employees of the group? If you answered yes to Q2.19.2, select not applicable.

- ☐ Yes
- ☐ No
- ☐ Not Applicable

Q2.19.5 - Which of the following are verified with the primary source (select all that apply)? If you answered *no* or *not applicable* to Q2.19.4, select not applicable.

- ☐ Graduation from relevant school
- ☐ Internship/residency/practicuum
- ☐ Specialty certification
- ☐ Work history (all hospitals at which privileges have been held)
- ☐ Experience
- ☐ Current state licensure(s)
- ☐ Sanctions/limitations on license to practice
- ☐ Malpractice insurance coverage
- ☐ National Practitioners Data Bank
- ☐ CMS Office of Inspector General sanctions
- ☐ Drug Enforcement Agency certificate
- ☐ Not Applicable

Q2.19.6 - Do you have a formal policy and procedure in place with respect to collaborative practice with nurse practitioners and/or physician assistants?

- ☐ Yes
- ☐ No

Q2.19.7 - If you answered *yes* to Q2.19.6, do the collaborative practice policies and procedures specify the minimum level of supervision with which each physician must comply when working with a nurse practitioner or a physician assistant? If you answered *no* to Q2.19.6, select not applicable.

- ☐ Yes
- ☐ No
- ☐ Not Applicable

Q2.19.8 - Does your group perform recredentialing and privileging at least every three years for each nurse practitioner and/or physician assistant?

- ☐ Yes
- ☐ No

Q2.19.9 - Which of the following indicators of performance are used in determining whether to continue to grant credentials and privileges to nurse practitioners and/or physician assistants (select all that apply)?

- ☐ Complaints from patients
- ☐ Incidents of disruptive behavior
- ☐ Returns to the ED within pre-set time period
- ☐ Returns to the ED within pre-set time period resulting in admission
- ☐ Unanticipated deaths within pre-set time period following ED visit
- ☐ Complaints from staff/colleagues

S2.20 - Locum Tenens

Q2.20.1 - Have you used locum tenens physicians in any of the EDs staffed by your group in the last three (3) years?
If you answer no, please go to S3 – High Risk Clinical Presentations.

- ☐ Yes
- ☐ No

Q2.20.2 - Do locum tenens physicians undergo the same credentialing process as other members of the group?

- ☐ Yes
- ☐ No

Q2.20.3 - Do locum tenens physicians have a formal orientation to the group?

- ☐ Yes
- ☐ No

S3 - High Risk Clinical Presentations

Q3.1 - Has your group developed and implemented protocols to guide the physicians' decision-making processes with respect to the following high risk clinical presentations (select all that apply)?

- ☐ Chest pain
- ☐ Abdominal pain
- ☐ Fever in children
- ☐ Stroke
- ☐ Impaired mental status
- ☐ Headache/head pain
- ☐ Trauma
- ☐ Spinal injury

Q3.2 - If your group has developed and implemented any of the foregoing protocols, do you periodically audit a sample of the medical records generated by each physician to ensure compliance with the protocols? If you have not developed any of the foregoing protocols, select not applicable.

- ☐ Yes
- ☐ No
- ☐ Not Applicable

Q3.3 - Has your group developed and implemented mechanisms by which "panic" laboratory results or radiological interpretations can be called immediately to the ED physician who ordered the test?

- ☐ Yes
- ☐ No

End of assessment.

Physician Group Practice Risk Assessment

Name of Applicant: _____

Corporate Address: _____
City: _____
State: _____

This addendum is supplemental to the general application incorporated by reference and with this policy issued in reliance therein.

S1 - Organization and Structure

Q1.1 (1.4) - Are there formal administrative policies and procedures in place for the management of the group practice?

☐ Yes
☐ No

Q1.2 (1.5) - Does the group practice have a leadership team that sets policy and procedure, and conducts oversight?

☐ Yes
☐ No

Q1.3 (1.6) - Does the group practice have the following (select all that apply)?

☐ Risk Management Committee
☐ Quality Improvement/Patient Safety Committee
☐ Credentialing Committee

S2 - Hiring, Credentialing and Recredentialing

Q2.1 - Do you have a formal application process for physicians?

☐ Yes
☐ No

Q2.2 - Do you conduct a criminal background check in all states of previous residence for all applicants?

☐ Yes
☐ No

Q2.3 - Do you have a formal credentialing process for application to the group practice?

☐ Yes
☐ No

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Q2.4 - If yes to the previous question, which of the following are verified with the primary source (select all that apply)? If no to Q2.3, select not applicable.

- ☐ Medical school
- ☐ Internship/residency
- ☐ Specialty board certification
- ☐ Work history
- ☐ Experience
- ☐ State licensure
- ☐ Sanctions/limitations on licensure
- ☐ Medical malpractice insurance coverage
- ☐ National Practitioners Data Bank
- ☐ Drug Enforcement Agency certificate
- ☐ CMS sanctions
- ☐ Not Applicable

Q2.5 - Do you require board certification for all physician members of your group practice? "Board eligible" does not equate to yes.

- ☐ Yes
- ☐ No

Q2.6 - Do you have a written procedure for the management of impaired providers?

- ☐ Yes
- ☐ No

Q2.7 - Do you have a written procedure for the management of disruptive behavior by care providers?

- ☐ Yes
- ☐ No

Q2.8 - Does the group practice have a policy and procedure in place to address drug testing that encompasses professional and non-professional staff?

- ☐ Yes
- ☐ No

S2.9 – Nurse Practitioners and Physician Assistants

Q2.9.1 - Does your group practice use nurse practitioners and/or physician assistants?
If you answer no, please go to S2.10 – Locum Tenens.

- ☐ Yes
- ☐ No

Q2.9.2 - Do nurse practitioners and/or physician assistants have a formal credentialing process as members/employees of the group practice?

- ☐ Yes
- ☐ No

Q2.9.3 - Which of the following are verified with the primary source (select all that apply)? If you answered *no* to Q2.9.2, select not applicable.

- ☐ School
- ☐ Internship/residency/practicuum
- ☐ Specialty certification
- ☐ Work history
- ☐ Experience
- ☐ State licensure
- ☐ Sanctions/limitations on licensure
- ☐ Malpractice insurance coverage
- ☐ National Practitioners Data Bank
- ☐ CMS sanctions
- ☐ Not Applicable

Q2.9.4 - Do you verify Drug Enforcement Agency certificate with the primary source? If nurse practitioners and/or physician assistants do not write prescriptions for controlled substances (level II), select not applicable.

Guidance:

Certain states may prohibit mid-level practitioners from writing prescriptions for controlled substances.

- ☐ Yes
- ☐ No
- ☐ Not Applicable

Q2.9.5 - Do you have a formal policy and procedure in place with respect to collaborative practice with nurse practitioners and/or physician assistants?

- ☐ Yes
- ☐ No

Q2.9.6 - If yes to Q2.9.5, is there a process in place for auditing compliance with the collaborative practice policy and procedure? If you answered *no* to Q2.9.5, select not applicable.

- ☐ Yes
- ☐ No
- ☐ Not Applicable

S2.10 - Locum Tenens

Q2.10.1 - Do you use locum tenens physicians in your group practice?
If you answer no, please go to S3 – Policies and Procedures.

- ☐ Yes
- ☐ No

Q2.10.2 - Do locum tenens physicians undergo the same credentialing process as other members of the group practice?

- ☐ Yes
- ☐ No

Q2.10.3 - Do locum tenens physicians have a formal orientation to the group practice?

- ☐ Yes
- ☐ No

S3 - Policies and Procedures

Q3.1 - Do you have written policies and procedures for the following (select all that apply)?

- ☐ Infection control
- ☐ Cleaning and sterilization of equipment
- ☐ Clinical equipment and device checks
- ☐ Clinical equipment calibration
- ☐ Planned maintenance of clinical equipment
- ☐ Stocking and distribution of medication samples
- ☐ Informed consent to treatment
- ☐ Refusal of consent to treatment
- ☐ Termination of treatment for non-compliant or disruptive patients
- ☐ Fire Safety
- ☐ Evacuation
- ☐ Mandatory Notification (e.g. elder abuse / child abuse)
- ☐ Health Information System back-up
- ☐ Closing of the group practice locations (weather / terrorism)
- ☐ After-hours call policy
- ☐ Email policy
- ☐ Patient notification of test results
- ☐ CLIA compliance

Q3.2 - Do you have a written policy and procedure for the storage and counting of all controlled medications? If controlled medications are not kept on office premises, select not applicable.

- ☐ Yes
- ☐ No
- ☐ Not Applicable

Q3.3 - Do you follow-up with patients for the following (select all that apply)?

- ☐ Missed or cancelled appointments
- ☐ Test results necessitating follow-up or specialist referral

Q3.4 - Does your group practice use a tickler system for outstanding test results or specialist referral reports?

- ☐ Yes
- ☐ No

S4 - Practice Guidelines & Monitoring of Clinical Care

Q4.1 - Has your group practice adopted standard protocols or practice guidelines for high volume diagnoses or surgeries?

- ☐ Yes
- ☐ No

Q4.2 - If yes to Q4.1, please check all that apply with respect to adopted standard protocols or practice guidelines. If no to Q4.1, select not applicable.

- ☐ Practice guidelines are reviewed at least annually.
- ☐ Associates are oriented to new and updated guidelines.
- ☐ Compliance with practice guidelines is monitored.
- ☐ There is a process for documenting variation.
- ☐ Not Applicable

Q4.3 - Is there an organized, documented process for peer review which includes the following (select all that apply)?

- ☐ Written review criteria
- ☐ Routine monitoring/record review
- ☐ Defined sampling plan of records/practitioners
- ☐ Aggregate data analysis
- ☐ Individual data analysis
- ☐ Peer review process occurs at least quarterly
- ☐ Peer review results are reported to the appropriate group committee for follow-up action

Q4.4 - Which of the following are routinely incorporated into peer review activities (select all that apply)?

- ☐ Complications and adverse outcomes
- ☐ Compliance with practice guidelines
- ☐ Incident/occurrence reports
- ☐ Patient/family complaints
- ☐ Patient/family satisfaction data
- ☐ Employee complaints

Q4.5 - Does the peer review process include nurse practitioners and physician assistants? If your group practice does not use nurse practitioners and/or physician assistants, select not applicable.

- ☐ Yes
- ☐ No
- ☐ Not Applicable

S5 - Patient Safety and Risk Management

Q5.1 - Is there a process in place for identifying risk exposures in the group practice related to the delivery of care?

- ☐ Yes
- ☐ No

Q5.2 - Is there a process in place for communicating to leadership of the group practice concerns about actual or identified risks impacting patient care?

- ☐ Yes
- ☐ No

Q5.3 - Do you have a formal program to obtain patient satisfaction?

- ☐ Yes
- ☐ No

Q5.4 - Do you have a procedure for follow-up of patient complaints?

☐ Yes

☐ No

Q5.5 - Do you record and track complaints?

☐ Yes

☐ No

Q5.6 - Do you have specific individual(s) assigned to answer and triage patient phone calls that have the professional level of RN, NP (Nurse Practitioner), PA (Physician Assistant), or physician?

☐ Yes

☐ No

S6 - Medical Record Information

Q6.1 - Medical records maintained by your group practice include which of the following (select all that apply)?

☐ Health questionnaires

☐ Medication lists

☐ Problem lists

☐ Allergies

Q6.2 - Are all test results and specialty referral reports read, signed and dated by the ordering care provider prior to the information being filed in the patient record?

☐ Yes

☐ No

Q6.3 - Is there a process for patient record auditing and review?

☐ Yes

☐ No

S7 - Invasive Procedures and Surgery

Q7.1 - Do you perform invasive procedures or surgery in the office?

If you answer no, this is the end of the assessment.

Guidance:

For purposes of this assessment, "office surgery" is defined as surgery which is performed outside a hospital, an ambulatory surgery center, clinic, or other medical facility.

☐ Yes

☐ No

Q7.2 - Do any physicians perform procedures for which they are not privileged at a hospital?

☐ Yes

☐ No

Q7.3 - Do you have and follow criteria for determining which patients are suitable for office-based procedures?

☐ Yes

☐ No

Q7.4 - Do you have transfer agreements in place with appropriate area hospitals?

☐ Yes

☐ No

S7.5 - General Anesthesia

The following questions apply to office settings using general anesthesia.

Q7.5.1 - Is general anesthesia administered within your office setting?
If you answer no, please go to S7.6 – Sedation.

☐ Yes

☐ No

Q7.5.2 - Which of the following non-physician anesthesia providers do you use for administration of general anesthesia (select all that apply)?

☐ CRNA

☐ Physician Assistant

☐ Anesthesia Assistant

Q7.5.3 - With respect to the guidelines for the supervision of non-physician anesthesia providers (e.g., CRNA, Physician Assistant, Anesthesia Assistant), select all that apply. If your group practice does not use non-physician anesthesia providers, select not applicable.

☐ Non-physician anesthesia provider scope of practice is clearly defined and in compliance with state law.

☐ There is peer review of non-physician anesthesia provider practices including outcomes and quality data.

☐ Not Applicable

S7.6 - Sedation

The following questions apply to office settings using moderate sedation/analgesia or deep sedation/analgesia.

Q7.6.1 - Is moderate sedation/analgesia or deep sedation/analgesia administered within your office setting?
If you answer no, please go to S7.7 – Anesthesia Care.

☐ Yes

☐ No

Q7.6.2 - Do you use licensed providers (Physician/CRNA/Physician Assistant/Anesthesia Assistant/RN) for administration of moderate sedation/analgesia or deep sedation/analgesia?

☐ Yes

☐ No

Q7.6.3 - When administering moderate sedation/analgesia or deep sedation/analgesia, is there an individual provider (nurse or physician) *other than* the physician performing the procedure, who is responsible for monitoring the patient?

☐ Yes

☐ No

Q7.6.4 - Is the individual's competency to monitor patients receiving moderate sedation/analgesia or deep sedation/analgesia monitored and confirmed at least annually?

☐ Yes

☐ No

S7.7 - Anesthesia Care

The following questions apply to anesthesia care in the office setting irrespective of whether moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia is administered. This subsection must be completed if you answered *yes to Q7.1 and completed one or both of subsections S7.6 and S7.7*.

Q7.7.1 - Do you confirm the presence of a designated driver for all patients receiving moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia?

- ☐ Yes
- ☐ No

Q7.7.2 - Do you cancel the procedure if a designated driver is not present prior to the initiation of the procedure?

- ☐ Yes
- ☐ No

Q7.7.3 - With respect to responding to an emergency, which of the following do you have (select all that apply)?

- ☐ An emergency response plan
- ☐ An appropriately-stocked crash cart
- ☐ An external defibrillator
- ☐ A procedure to check the crash cart regularly

Q7.7.4 - Do you conduct mock code drills at least annually?

- ☐ Yes
- ☐ No

Q7.7.5 - Is an individual who is ACLS-certified always available when moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia is administered in the office?

- ☐ Yes
- ☐ No

Q7.7.6 - Is there a formal policy and procedure in place for post-procedure monitoring of patients?

- ☐ Yes
- ☐ No

Q7.7.7 - Is post-procedure monitoring of patients supervised by an RN?

- ☐ Yes
- ☐ No

End of assessment.