

## **Professional & General Liability Application for Pharmacies**

1. Name of Applicant: (as it should appear on the policy)	
2. Mailing Address:	
3. Location Address:	eceipts by location)
4. Telephone Number: Website Addre	ss:
5. Exposure:	
Gross Receipts for the Past 12 Months:	\$
Estimated Gross Receipts for the Next 12 Months:	\$
Payroll for the Past 12 Months:	\$
Estimated Payroll for the Next 12 Months:	\$
Number of Prescriptions Filled over the Past 12 Months:	
Estimated Number of Prescriptions Filled for Next 12 Months:	
6. Description of Services Provided:	
7. Does the applicant own or manage any other businesses or locations  Yes No  If yes, is there separate professional and general liability coverage for minimum of \$1M/\$3M limits and does the applicant agree to mainta operations throughout the duration of this policy?  Yes No	or these other operations elsewhere at a
8. Is the applicant a member of any association or certified or accredite	ed by any governing body? If yes, give details

9. Exposure: Please complete the table below showing the % exposure in each of the areas listed in terms.

 $\underline{\text{NOTE}}$ : If this is a start-up business not yet in operation, please show estimated % exposures for the next 12 months in each of the areas listed.

	% Exposure
Compounding Medications	
Dispensing of Opioids	
Drug Benefit Services	
Mail Order	
Retail	
Wholesale	
Specialized Pharmacy Services (e.g. Veterinarian services)	
Grow, Blend or Prepare Medical Marijuana and/or Herbal Remedies	
Other (please describe):	
11. Do you sell, rent or otherwise provide any equipment to products or others?  Yes	
If yes, please complete the supplement for Durable Medical Equipment Sales/Rentals	•
12. Do you dispense any drugs that are:	
a) Imported from outside of the United States of America? Yes No	
If yes, provide details:	
b) Not FDA approved? Yes No	
If yes, provide details:	
13. Are all prescriptions authorized by a licensed physician licensed in the state where services	s are provided?
Yes No If no, provide details:	

14. Are you in compliance with all local, state and federal laws that govern the manufacture, control, dispensing and distribution of prescription drugs?
Yes No If no, provide details:
15. Are telephone orders only taken by a pharmacist and repeated back for verification?  Yes No
16. Are products with known look-alike drug names stored separately and not alphabetically?
Yes No
17. Does the applicant perform pediatric dose range checks? Yes No
18. Are all prescriptions dispensed with current written instructions? Yes No
19. Does the applicant accept electronic prescriptions? Yes No
If yes, what controls are in place to ensure prescriptions are prescribed by a licensed physician?
20. How are drug waste and expired drugs disposed of?

21. a) List the number and type of <u>employees/owners</u> including any estimated over the next 12 months:

	<u>Number</u>		<u>Number</u>
Pharmacist		Pharmacy Technician	
Physician (patient contact)		Physician (no patient contact)	
Physician Assistant		Nurse Practitioner	
Nurse		Paramedic/EMT	
Physical/Occupational/Speech Therapist		Non-Medical Aide/Caregiver	
Chiropractor		Acupuncturist	
Admin/Clerical		Other (please describe)	

b) List the number and type of <u>independent contractors</u> including any estimated over the next 12 months:

	<u>Number</u>		<u>Number</u>
Pharmacist		Pharmacy Technician	
Physician (patient contact)		Physician (no patient contact)	
Physician Assistant		Nurse Practitioner	
Nurse		Paramedic/EMT	
Physical/Occupational/Speech Therapist		Non-Medical Aide/Caregiver	
Chiropractor		Acupuncturist	
Admin/Clerical		Other (please describe)	

c) Are all the individual regulations?	luals listed in resp	oonse to Q17a & b licensed in accorda	nce with applicable s	state and federal
	No	If no, attach explanation	on.	
22. Do you require co of Insurance as evide		any) to carry their own Professional L rage?	iability Insurance &	secure certificates
Yes No	If:	yes, at what limits? \$/	\$	
	hich of the follow	limits on this policy? Yes ving you obtain, review, verify and keening process:		ne employee/
			Yes	<u>No</u>
Employment Applic	cation			
Criminal Backgroun	nd Checks			
Drug / HIV/ Hepati	tis Testing			
Licenses Held				
Education/Training	/Competence			
Multi-State Registry	У			

24.	Additional	employ	vment re	lated o	uestions:

	Yes	<u>No</u>
Do you question prospective employees/independent contractors about prior claims or suits?		
Are employees required to actively participate in continuing education?		
Do you prepare job descriptions and instructional manuals for your staff?		
Do you have a written incident/occurrence reporting policy and procedures?		
Are all owners/employees/independent contractors current on any training that is required by the state or any other governing body, and is there proof of any required training on file at the home/facility for review?		

25. Please complete the table below showing the applicant's Professional Liability coverage for last 5 years: (if none, state none)

<u>Carrier</u>	<u>Limit</u>	<u>Deductible</u>	<u>Premium</u>	Expiration Date	Retro Date (if applicable)

26. Please complete the table below showing the applicant's General Liability coverage for last 5 years: (if none, state none)

<u>Carrier</u>	<u>Limit</u>	<u>Deductible</u>	<u>Premium</u>	Expiration Date	Retro Date (if applicable)

27. Has the applicant or have any of their employees (please attach a detailed explanation for any "yes" answers):

	Yes	<u>No</u>
a) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital or professional association?		
b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?		
c) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?		
d) Ever had an application for Professional Liability Insurance made on their behalf which has been declined or has their insurance ever been cancelled or renewal refused?		

Yes	No	If yes, please attach completed claims supplement.
		nstances which may result in any claim against him, the firm, his present or past Partners or Officers?
Yes	No	If yes, please attached a separate sheet with date(s) and details.
Application does rethe basis of the consuch Policy, if issued	not bind the undersigr ntract should a Policy	st of his/her knowledge the statements herein are true. Signing of this ned to complete the insurance, but it is agreed that this Application shall be be issued, and that this Application will be attached and become part of be are authorized to make any investigation and inquiry in connection with y.
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