ALLIED MEDICAL PHARMACY HEALTHCARE PROFESSIONAL LIABILITY APPLICATION

Instructions: Please answer all questions. If a question does not apply, state "N/A." Attach additional sheets if needed. The applicant's name must include all businesses and locations for which coverage is desired.
Please type or print in ink.

GENERAL INFORMATION

1. Entity Name:_____

2. Mailing Address:_____

_____

3. Location Address(es):_____

4. Date Established:_____

5. Business Structure (check one):

[ ] Sole Practitioner [ ] Corporation
[ ] Sole Proprietorship [ ] Partnership
[ ] Other; Describe:_____

6. List memberships in professional organizations:_____

RISK PROFILE

7. Annual Gross Receipts:

	Last 12 Months	Next 12 Months
Prescription Sales:		
Sundries Sales:		
Medical Equipment Sales:		
Medical Equipment Rental:		
In Home Therapy:		
Other: _____		
TOTAL:		

8. Provide the percentage of services rendered:

Compounding	_____ %
Drug Benefit	_____ %
Mail Order	_____ %
Retail	_____ %
Wholesale	_____ %
Other_____	_____ %
Total	100%

9. Provide the types of medical supplies and/or equipment that the Applicants sells, leases or repairs for others:

Type	**Estimated Annual Receipts**	
	Last 12 Months	**Current 12 Months**

10. Total number of professional employees employed by the Applicant: _____

11. (a) Provide the number of persons employed by the Applicant for each of the following:

_____ Pharmacists _____ Pharmacy Technicians

_____ Pharmacy Technicians _____ RNs

_____ Respiratory Therapists _____ Other (describe) _____

(b) Are the above individuals:

(i) All licensed in accordance with applicable state and federal regulations? [ ] Yes [ ] No

a. If No, provide details. _____

(ii) Any licensed or authorized in accordance with applicable state law to document medical necessity for marijuana use? [ ] Yes [ ] No

12. Does the Applicant supervise or contract with any individual other than its own employees? [ ] Yes [ ] No

If Yes,

(a) Provide an explanation of responsibilities and a description of the Applicant's relationship to the organization which employs these individuals. _____

_____

(b) Does the Applicant require all contracted staff to carry their own Professional Liability Insurance? [ ] Yes [ ] No

If Yes,

(i) What are the minimum limits of liability that are required? _____

(ii) Does the Applicant require Certificates of Insurance? [ ] Yes [ ] No

13. Does the Applicant have any operations outside of the United States of America? [ ] Yes [ ] No

If Yes, provide details._____

14. Are all prescriptions authorized by a licensed physician licensed in the state where services are rendered? [ ] Yes [ ] No

If No, provide details. _____

15. Does the Applicant dispense any drugs that are:

(a) Imported from outside the United States of America? [ ] Yes [ ] No

If Yes, provide details._____

_____

(b) Not FDA approved? [ ] Yes [ ] No

If Yes, provide details._____

_____

16. Is the Applicant 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._____

17. Number of prescriptions filled during the last twelve (12) months:_____

18. Does the Applicant:

(a) Provide mail order services? [ ] Yes [ ] No

If Yes, provide details of safety controls used to assure a licensed physician has authorized prescriptions._____

(b) Provide Pharmacy Benefit Management services, including, formulary management and design, medical necessity review, credentialing review, pharmacy data and supporting services? [ ] Yes [ ] No

If Yes, attach a list of the Applicant's five (5) largest clients and provide a copy of a sample contract.

(c) Compound in bulk, manufacture or wholesale drugs or products? [ ] Yes [ ] No

If Yes, are active ingredients purchased from chemical factories that are registered with the FDA? [ ] Yes [ ] No

(d) Provide specialized pharmacy services such as nuclear or veterinarian services? [ ] Yes [ ] No

If Yes, provide details. _____

19. Does the Applicant provide services to the following:

(a) Correctional Facility [ ] Yes [ ] No

(b) Hospital [ ] Yes [ ] No

(c) Long Term Care Facility [ ] Yes [ ] No

(d) If any of the above is Yes, provide a copy of a sample contract for each Yes answer.

20. Does the Applicant grow, blend or prepare for use medical marijuana and/or herbal medicinal remedies? [ ] Yes [ ] No

If Yes, attach a completed Supplement for Medical Marijuana Dispensing.

21. Is the Applicant a member of Institute for Safe Medication Practices (ISMP)? [ ] Yes [ ] No

RISK MANAGEMENT

22. Are telephone orders only taken by a pharmacist from authorized professional staff and repeated back to the prescriber for verification? [ ] Yes [ ] No

22. a. Are products with known look-alike drug names stored separately and not alphabetically? [ ] Yes [ ] No

b. Are special alerts built into the system concerning problematic or look-alike drug names, packaging or labeling? [ ] Yes [ ] No

c. What safety controls are in place to address problematic or look-alike drug names, packaging or labeling? _____

_____

24. Does the Applicant have access to drug information (i.e., Drug Facts and Comparisons, Micromedex, etc.)? [ ] Yes [ ] No

25. Does the Applicant perform pediatric dose range checks? [ ] Yes [ ] No

26. How does the Applicant detect drug contraindications, interactions, duplications against medical history and other prescribed drugs? _____

_____

27. What criteria are established (i.e. targeted high-alert drugs, patient population) to trigger required medication counseling (i.e. alert tag)? _____

28. Are all prescriptions dispensed with current written instructions? [ ] Yes [ ] No

29. Does the Applicant accept electronic prescriptions? [ ] Yes [ ] No

If Yes,

(a) What safety controls are in place to assure prescriptions are prescribed by a licensed physician?_____

_____

30. How is drug waste and expired drugs disposed?_____

_____

HISTORY

31. List prior **professional liability** insurers for the past three years, starting with the most recent year. If none, state none.

Insurer	Limit of liability	Premium	Effective Dates	Claims-made or Occurrence?

What is the most recent retroactive date?_____

32. List prior **general liability** insurers for the past three years, starting with the most recent year. If none, state none.

Insurer	Limit of liability	Premium	Effective Dates	Claims-made or Occurrence?

What is the most recent retroactive date?_____

33. Has the applicant or have any of the above employees:

a. ever been the subject of disciplinary or investigative proceedings or reprimand 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

d. 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? [ ] Yes [ ] No

If Yes to any of the above, please explain.

_____

_____

_____

_____

34. Have any claims been made or accidents reported during the past five years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest? [ ] No [ ] Yes

If yes, please describe; indicate status of the claim or suit and any amount(s) paid or reserved (attach an additional sheet if necessary):

_____

_____

_____

_____

35. Does any proposed insured have any knowledge of an event, circumstance, or accident (other than any listed in 4.4 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance, or occurrence? [ ] No [ ] Yes

If yes, describe the event and indicate the reason for anticipation of a claim:

_____

_____

_____

I understand and agree this Application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this Application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation, and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and Diamarc Underwriters LLC, any documents, records, or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicants and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and applicant has not withheld information which is calculated to influence the judgment of the insurance company in considering this application.

Important: This application must be dated and signed by the applicant owner, partner, officer or administrator. Signing this form does NOT bind the company to complete the insurance.

_____

Applicant Signature

_____

Title

_____

Date