Virginia Rose Insurance Agency
817-680-9401

IV Center Application

PROFESSIONAL LIABILITY

Please email application to rwilliams@virginiaroseinsurance.com

All questions MUST be completed in full.
If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. Full name of Applicant: _____
2. Full address of Applicant: _____

_____

(City) (State) (Zip) (County)

II. OPERATIONS

1. What is your professional specialty? _____

_____

2. What are your annual Gross Revenues?_____

3. Medical Director – Administrative Duties

   a. Does your facility(ies) have a Medical Director? ❑Yes ❑ No
   If yes, please provide their name:_____

   b. Is the Medical Director a physician? ❑Yes ❑ No
   If no, please describe credentials of Medical Director :_____

   c. Describe the duties of the Medical Director (attach separate sheet if necessary):_____

   _____

   d. Indicate the days and hours when the Medical Director is present in the office: _____

   e. Does the Medical Director have professional liability coverage that will cover his or her administrative duties?

   ❑Yes ❑ No

   f. Current Medical Director is :____ Owner/Partner ____ Independent Contractor ____ Employee ____ Other

   g. If not the Medical Director, who is responsible for the day to day operation of your facility(ies)? _____

4. Provide the percentage of the Applicant's patients/clients in the following categories:

Chelation Therapy	_____%	Cellulite	_____%
Dermatology	_____%	Hair Removal (Non laser)	_____%
Massage	_____%	Hair Removal (laser – Skin types I-IV only)	_____%
Scherotherapy	_____%	Laser Hair Stimulation	_____%
Dermatology	_____%	Laser/LED Treatments – Basic	_____%
Veins	_____%	Weight Control	_____%
Tattoo Removal	_____%	Acne Treatment	_____%
Teeth Whitening	_____%	Age spots	_____%
Mesotherapy	_____**%**	**TOTAL**	**100**%

5. Applicant's staff:				
Staff	**# of Full Time Employees**	**# of Part Time Employees**	**# of Independent Contractors ***	**Are they licensed/certified by state?**
Supervising physician **OF** laser procedures				
Physician **PERFORMING** laser procedures				
Supervising physician for all other services (non laser)				
Aestheticians				
Dermatologist				
Administrator				
Physicians Assistants				
Nurse Practitioners				
Massage Therapists				
Licensed Nurses (RN,LVN,LPN)				
Nurse, medical technician for Dermal Fillers				
Other (fully describe)				
* Do you require coverage for independent contractors? ❑Yes ❑ No				

6. List all manufactured equipment and drugs used in the Applicant's practice and the purpose for which each is used. Attach separate sheet if necessary:

Equipment/Drug	**Purpose**	**Used only as approved by the FDA? (Yes or No)**	**If No, describe off-label usage.**

7. Are any non-FDA approved treatments or procedures provided? ❑Yes ❑ No

8. Does the Applicant take before and after pictures of every patient? ❑Yes ❑ No

If No, explain. _____

_____

9. Must all clients sign a patient consent form specific to the procedures to be performed prior to treatment? .❑Yes ❑ No
If No, explain. _____

10. Do you perform procedures on patients younger than16 years old? ❑Yes ❑ No

11. Do you utilize a formal written Quality Assurance & Risk Management Program? ❑Yes ❑ No
If No, please explain_____

12. Do you have overnight beds? ❑Yes ❑ No
If yes, how many total persons can you accommodate at any one time? _____
Fully describe the use of overnight beds_____

III. PROCEDURES

1. **BOTOX INJECTIONS** -

Does the Applicant perform Botox Injections? ❑Yes ❑ No

If Yes, complete the following:

a. Total number of Botox Injections: (i) Past 12 months: _____ (ii) Next 12 months: _____

b. Who performs Botox Injections?

_____ Physician _____ Physician's Assistant _____ Nurse
_____ Dentist _____ Nurse Practitioner _____ Other-describe:_____

c. Have all staff performing Botox Injections:

(i) Received a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? ❑Yes ❑ No

(ii) Performed a minimum of ten procedures on live patients? ❑Yes ❑ No

d. Does the Applicant have a physician available for consultation and complications? ❑Yes ❑ No

If Yes,

(i) Has this physician completed a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient?

(ii) Does the physician have Medical Malpractice Liability Insurance for this activity? ❑Yes ❑ No

2. **CHEMICAL PEELS** –

Does the Applicant perform Chemical Peels? ❑Yes ❑ No

If Yes, complete the following:

a. Total number of Chemical Peels with solution strength <30%:..(i) Past 12 months: _____ (ii) Next 12 months: _____

(i) Who performs Chemical Peels with solution strength <30%:

____Physician ____ Physician's Assistant ____ Nurse
____Dentist ___ Nurse Practitioner ____ Other-describe: _____

(ii) Have all staff performing Chemical Peels with solution strength <30% received a minimum of eight hours training specifically for this procedure including anatomy, physiology, skin typing, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? ❑Yes ❑ No

b. Total number of Chemical Peels with solution strength >30%:..(i) Past 12 months: _____ (ii) Next 12 months: _____

(i) Who performs Chemical Peels with solution strength >30%:

____Physician ____ Physician's Assistant ____ Nurse
____Dentist ___ Nurse Practitioner ____ Other-describe: _____

(ii) Are all staff performing Chemical Peels with solution strength >30% licensed physicians with a specialty of Dermatology or Plastic Surgery? ❑Yes ❑ No

3. **DERMAL FILLERS** –

Does the Applicant perform Dermal Fillers (such as Artefill, Collagen, Hylaform, Restylane)? ❑Yes ❑ No

If Yes, complete the following:

a. Total number of Dermal Fillers: .....(i) Past 12 months: _____ (ii) Next 12 months: _____

b. Who performs Dermal Fillers?

_____ Physician _____ Physician's Assistant _____ Nurse
_____ Dentist _____ Nurse Practitioner _____ Other _____

c. Have all staff performing Dermal Fillers:

(i) Received a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? ❑Yes ❑ No

(ii) Performed a minimum of five procedures on live patients? ❑Yes ❑ No

d. Does the Applicant have a physician available for consultation and complications? ❑Yes ❑ No

If Yes,

(i) Has this physician completed a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? ❑Yes ❑ No

(ii) Does this physician have Medical Malpractice Liability Insurance for this activity? ❑Yes ❑ No

e. Does the Applicant

(i) Use only dermal fillers approved by the FDA? ❑Yes ❑ No

If No, explain:_____

(ii) Disclose off-label use to all patients receiving such treatment on the patient consent form? ❑Yes ❑ No

4. **LASER SKIN TREATMENTS** -

Does the Applicant perform Laser Skin Treatments including Laser Hair Removal, IPL (Intense Pulse Light Treatments), Acne Blue Light Treatments, and Laser Vein Treatments? ❑Yes ❑ No

If Yes, complete the following:

a. Total number of Laser Skin Treatments: .....(i) Past 12 months: _____ (ii) Next 12 months: _____

b. Who performs Laser Skin Treatments Injections?

_____ Physician _____ Physician's Assistant _____ Nurse

_____ Dentist _____ Nurse Practitioner _____ Other-describe: _____

c. Does the Applicant comply with the following standards of practice:

(i) Individuals are trained in laser physics, tissue interaction, laser safety, clinical application, pre-operative care, and post-operative care of the laser patient. ❑Yes ❑ No

(ii) Prior to the initiation of any patient care activity the individual has read and sign the clinic's policies and procedures regarding the safe use of lasers. ❑Yes ❑ No

(iii) Continuing education of all licensed medical professionals is mandatory and made available with reasonable frequency (including outside the office setting) to help insure adequate performance. ❑Yes ❑ No

(iv) A minimum of ten procedures of precepted training is required for each laser procedure and laser type to assess competency. Participation in all training programs, acquisition of new skills and number of hours spent in maintaining proficiency is well documented. ❑Yes ❑ No

(v) After demonstrating competency to act alone, the designated licensed medical professional may perform limited laser treatments on specific patients as directed by the supervising physician. ❑Yes ❑ No

d. Does the Applicant comply with the following standards of practice for non-physicians use of laser related technology:

(i) Any physician who delegates a procedure to a non-physician must be qualified to do these laser procedures themselves by virtue of having received appropriate training in physics, safety, surgical techniques, pre and post operative care, and be able to handle the resultant emergencies or sequela. ❑Yes ❑ No

(ii) Any licensed medical professional employed by a physician to perform a procedure has received appropriate documented training and education in the safe and effective use of each system and are a licensed medical professional in the state of practice. ❑Yes ❑ No

(iii) A properly trained and licensed medical professional carries out these specifically designed procedures only under the direct, on-site physician supervision and following written procedures. ❑Yes ❑ No

(iv) The supervising physician is available on-site to respond to any untoward event that may occur.. ❑Yes ❑ No

5. **MASSAGE THERAPY/CELLULITE TREATMENTS** -

Does the Applicant perform Massage Therapy/Cellulite Treatments? ❑Yes ❑ No

If Yes, complete the following:

a. Total number of Massage Therapy / Cellulite Treatments: .....(i) Past 12 months: _____ (ii) Next 12 months: _____

b. Who performs Massage Therapy / Cellulite Treatments?

_____ Physician _____ Physician's Assistant _____ Nurse

_____ Massage Therapist _____ Nurse Practitioner _____ Other-describe: _____

c. Are all staff performing Massage Therapy / Cellulite Treatments licensed, registered or certified according to state requirements? ❑Yes ❑ No

If No, explain. _____

6. **MESOTHERAPY AND/OR LIPODISSOLVE -**

Does the Applicant perform Mesotherapy and/or Lipodissolve at this clinic? ❑Yes ❑ No

If Yes, complete the following:

a. Total number of Mesotherapy/Lipodissolve Treatments: .....(i) Past 12 months: _____ (ii) Next 12 months: _____

b Who performs Mesotherapy/Lipodissolve at this clinic?.

_____ Physician _____ Physician's Assistant _____ Nurse

_____ Dentist _____ Nurse Practitioner _____ Other-describe:_____

c. Are all staff performing Mesotherapy and/or Lipodissolve licensed physicians with a minimum of eight hours training to perform Mesotherapy and/or Lipodissolve including anatomy, physiology, contraindications, potential complications, and performance of at least one procedure on each part of the anatomy for which coverage is desired? ❑Yes ❑ No

7. **MICRODERMABRAISIONS** –

Does the Applicant perform Microdermabrasions? ❑Yes ❑ No

If Yes, complete the following:

a. Total number of Microdermabrasions: .....(i) Past 12 months: _____ (ii) Next 12 months: _____

b. Who performs Microdermabrasion:

_____ Physician _____ Physician's Assistant _____ Nurse

_____ Dentist _____ Nurse Practitioner _____ Other-describe:_____

c. Have all staff performing Microdermabrasion treatments received a minimum of eight hours training including specific training for the equipment being used, skin typing, contraindications, potential complications, and performance of at least one procedure on a live patient? ❑Yes ❑ No

If No, explain: _____

8. **MICROPIGMENTATION/PERMANENT MAKEUP** -

Does Applicant perform Micropigmentation / Permanent Makeup? ❑Yes ❑ No

If Yes, complete the following:

a. Total number of Permanent Makeup / Micropigmentations: ...(i) Past 12 months: _____ (ii) Next 12 months: _____

b. Who performs Permanent Makeup / Micropigmentations:

_____ Physician _____ Physician's Assistant _____ Nurse

_____ Dentist _____ Nurse Practitioner _____ Other-describe:_____

c. Have all staff performing Permanent Makeup / Micropigmentation treatments received a minimum of eight hours training including specific training for the equipment being used, skin typing, contraindications, potential complications, and performance of at least one procedure on a live patient? ❑Yes ❑ No

If No, explain: _____

9. **SCLEROTHERAPY INJECTIONS** -

Does the Applicant perform Sclerotherapy Injections? ❑Yes ❑ No

If Yes, complete the following:

a. Total number of Sclerotherapy Injections: .....(i) Past 12 months: _____ (ii) Next 12 months: _____

b. Who performs Sclerotherapy Injections?

_____ Physician _____ Physician's Assistant _____ Nurse

_____ Dentist _____ Nurse Practitioner _____ Other-describe:_____

c. Are all staff performing Sclerotherapy Injections physicians who have received a minimum of eight hours training specific for this procedure, including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of a minimum of one procedure on a live patient? ❑Yes ❑ No

10. **TATTOO REMOVALS** -

Does the Applicant perform Tattoo Removals? ❑Yes ❑ No

If Yes, complete the following:

a. Total number of Tattoo Removals: .....(i) Past 12 months: _____ (ii) Next 12 months: _____

b. Who performs Tattoo Removal:

_____ Physician _____ Physician's Assistant _____ Nurse

_____ Dentist _____ Nurse Practitioner _____ Other-describe:_____

c. Are all staff performing Tattoo Removal licensed physicians who comply with the following standards of practice:

(i) Physicians are trained appropriately in laser physics, tissue interaction, laser safety, clinical application, pre-operative care, and post-operative care of the laser patient. ❑Yes ❑ No

(ii) Prior to the initiation of any patient care activity the physician has read and signed the clinic's policies and procedures regarding the safe use of lasers. ❑Yes ❑ No

(iii) Continuing education of all physicians is mandatory and made available with reasonable frequency (including outside the office setting) to help insure adequate performance. (Specific credit hour requirements will be determined by the state and/or individual clinic.) ❑Yes ❑ No

IV. **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
IF NO PRIOR COVERAGE, COMPLETE ATTACHED CLAIM SUPPLEMENT

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: _____
_____

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.

/		
Applicant's Signature	**Title**	**Date**