West Virginia Board of Risk & Insurance Management

HOSPITAL AND MEDICAL CARE FACILITY
PROFESSIONAL LIABILITY APPLICATION

Name of entity			
Entity address			
City	State	Zip Code	County
Phone number	Fax number		FEIN
Organization status ☐ Profit ☐ Nonprofit ☐ Charitable			
Accreditation by: ☐ JCAHO ☐ AOA ☐ CARF ☐ Other *specify*			
Annual Receipts $	Annual Payroll $		Average Census
Total Staff	Total – Pt. Care Staff		

	Day Shift (first)	Evening Shift (second)	Midnight Shift (third)
Staff to patient ratio			
Total number of patient care staff			
Number of temporary employees			

How many physicians do you employ? *please provide separate list*			
How many of the following allied professionals do you employ? (*40 hours =1; 20 hours =1/2, etc).*			
	Nurse Anesthetists		Physical Therapists
	Oral Surgeons		Optometrists
	Other Dentists		Pharmacists
	Nurse Midwives		

Your facility is: *please mark all that apply*

	Children's Hospital		Individual
	Geriatric Hospital		Partnership
	General Hospital		Corporation
	Psychiatric Hospital		Joint Venture
	Rehabilitation Hospital		Government
	Teaching Hospital		
	Other *please specify*		

Do you operate an Emergency Room? ☐ yes ☐ no
Level of care given in Emergency Room? ☐ Level I ☐ Level II ☐ Level III ☐ Level IV

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Prior Insurance History

Policy Period	Insurer	Limits	Coverage	Premium

Facilities and Services Available *please mark all that apply*

	Abortion Clinic		Ambulance		Blood Bank
	Burn Unit		CCU		Coronary Rescue
	Day Care		Dialysis		Dietary
	Emergency		Gift Shop		ICU
	Inhalation Therapy		Long-Term Care		Morgue
	Neonatal ICU		Nursery		Obstetrical
	Open Heart		Operating Rooms		Pathology
	Pharmacy		Physical Therapy		Radiation Therapy
	Radiology		Restaurant		Self-Care
	Shock Trauma		X-Ray		

Do you have clinical research under the auspices of an institutional review board? ☐ yes ☐ no
Do you administer non-FDA approved pharmaceuticals (experimental drugs)? ☐ yes ☐ no
Do you engage in biomedical research and development? ☐ yes ☐ no

Subacute Care:	Registered Beds		Occupancy Rate	
Skilled Care:	Registered Beds		Occupancy Rate	
Intermediate Care:	Registered Beds		Occupancy Rate	
Assisted Living:	Registered Beds		Occupancy Rate	
Independent Living:	Registered Beds		Occupancy Rate	

List all outpatient services provided by your facility *use separate sheets as necessary*

Service	Description	Visits per year

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What professional services do you contract out and what professional liability insurance limits do you require?
use separate sheets as necessary

Professional Services	Insurance Limits

Do you offer the following services?

SERVICE			NO. OF PATIENTS
Drug rehab	☐ yes ☐ no	*if yes*	
Alcohol rehab	☐ yes ☐ no	*if yes*	
Mental Health/Mental Retardation	☐ yes ☐ no	*if yes*	
Alzheimer's unit	☐ yes ☐ no	*if yes*	

Your facility has: *mark all that apply*

	Swimming pool		Hot tub/sauna
	Exercise/weight room		Other *specify*
If any of these are open to the general public, please identify:			

Have your licenses or certifications ever been suspended, revoked or placed on probation? ☐ yes ☐ no	
If yes, please explain. *use separate sheets as necessary*	
Do you operate a heliport ☐ yes ☐ no	Do you have an ambulance or other emergency vehicle ☐ yes ☐ no
If yes, please list and describe:	

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED HEREIN IS COMPLETE, ACCURATE AND TRUTHFUL TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT MISREPRESENTATIONS IN THIS APPLICATION MAY RESULT IN CANCELLATION OR RESCISSION OF COVERAGE. I UNDERSTAND AND AGREE THAT MY POLICY MAY BE ASSIGNED, INDIVIDUALLY OR COLLECTIVELY, PURSUANT TO STATUTE, TO A THIRD PARTY IF THE THIRD PARTY COVERAGE IS COMPARABLE, AS DETERMINED BY THE WEST VIRGINIA BOARD OF RISK AND INSURANCE MANAGEMENT. I FURTHER AGREE TO REMIT PREMIUMS FOR COVERAGE IN A TIMELY MANNER IF COVERAGE IS PROVIDED THROUGH THE WEST VIRGINIA BOARD OF RISK AND INSURANCE MANAGEMENT AND UNDERSTAND THAT FAILURE TO PAY SUCH PREMIUM IN A TIMELY AGREED MANNER MAY RESULT IN CANCELLATION OF COVERAGE.

Applicant Signature _____ Date _____