



Non-Direct Healthcare Services Supplemental Application New Business

Instructions:

- This application must be completed in addition to the Healthcare Facility General Application for Liability Insurance.
- Please print or type clearly all responses and answer all questions as instructed.
- If you need more space for a response, continue in the Comments section of this application or attach a separate sheet of paper.
- Coverage will not be considered until this supplemental application and the general application are completed and all required documents are provided.

Name of Applicant: _____
 (Whenever used, the term "Applicant" shall mean all entities proposed for coverage.)

Indicate the type of service(s) provided by the Applicant and complete the sections as instructed.

TYPE OF SERVICE

- Laboratory
- Pharmacy
- Blood/Plasma Bank
- Organ Bank

APPLICATION INSTRUCTIONS

- Complete Sections A and B
- Complete Sections A and C
- Complete Sections A and D
- Complete Sections A and E

A. General Information

1. Specify where services are provided:

- | | | |
|---|--|--|
| <input type="checkbox"/> Free Standing | <input type="checkbox"/> Hospital | <input type="checkbox"/> Outpatient Facility |
| <input type="checkbox"/> Inpatient Facility | <input type="checkbox"/> Long Term Care Facility | <input type="checkbox"/> Physician Office |
| <input type="checkbox"/> Other (specify): _____ | | |

2. Is the Applicant involved in any research activities? Yes No
 If yes, please describe the research activity in the Comments section.

3. Include all states in which business is conducted: _____

4. Are management services performed for other facilities? Yes No
 If yes, please describe the services provided in the Comments section.

B. Laboratory

1. Does the Applicant provide any of the following services?

- Assisted Reproductive Treatment/Techniques
- Paternity Testing
- Cytology

2. Is sperm or embryo storage provided? Yes No

C. Pharmacy

1. Does the Applicant manufacture any drugs or drug products? Yes No
 If yes, please describe in the Comments section.

2. Are any of the following services provided? Please indicate if not applicable. N/A

- Administration of Medication Case Management Compounding
 Pain Management Patient Monitoring

If any of these services are provided, please further describe the service in the Comments section and include the percentage these services represent in comparison to all services provided.

D. Blood/Plasma Bank

1. Does the Applicant check with the Donor Deferral Register before donor blood is taken and/or transfused? Yes No
2. Is a list of deferred donors maintained to prevent the use of collections from them? Yes No
3. Is Nucleic Acid Testing (NAT) performed?
 If yes, what percentage of blood is tested by this means? _____ %
4. Is leukoreduction performed? Yes No
5. Is pathogen inactivation performed? Yes No
6. Have FDA recommendations been implemented for the following:
- a. Preventative measures to reduce the possible risk or transmission of CJD and VCJD? Yes No
 - b. Assessment of donor suitability and blood and blood product in cases of possible exposure to anthrax? Yes No
 - c. Questions related to potential donors who have recently received the smallpox vaccine? Yes No
 - d. Quarantine and disposition of prior collections from donors with repeatedly reactive screening tests for HCV? Yes No
7. Is Applicant involved in any operations other than blood banking?
 If yes, describe in the Comments section. Yes No
8. Does Applicant contract with another facility to test blood on their behalf? Yes No
 If yes, please answer the following questions.
- a. Is there a contract in place between Applicant and the other facility? Yes No
 - b. What professional liability limits does Applicant require the facility to carry? \$ _____
 - c. Is a copy of their most recent FDA report kept on file? Yes No
 - d. Provide the type of test(s) and total number of tests performed on an annual basis: _____

E. Organ/Sperm/Embryo Bank

1. What is handled, stored or processed by the Applicant?
- Tissue Organ Sperm Embryo Bone Marrow
 Other (specify): _____
2. Indicate which types of services are provided?
- Recovery Processing Storage Evaluation Distribution
 Determination of Donor Eligibility Other (specify): _____
3. What is the percentage of donor distribution?

Donor Distribution	Percentage	Donor Distribution	Percentage
For Transplant	%	For Teaching	%
For Research	%	Other (describe):	%

