

## MEDICAL FACILITIES – AMBULATORY SURGERY CENTER SUPPLEMENTAL APPLICATION

THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.

1.	Applicant Name (as identified in the Liability Insurance Application for proposed insurance):					
2.	Indicate the total number of outpatient surgeries: Last 12 Months_____ Next 12 Months(Projected):_____					
3.	Please provide the number of procedures by category performed during the last 12 months and estimated for the next 12 months:					
		Last 12 Months	Next 12 Months		Last 12 Months	Next 12 Months
	Bariatric Surgery			Ophthalmology/Cataract		
	Cardiovascular			Ophthalmology – Other		
	Colon and Rectal			Orthopedic Surgery		
	ENT			Pain Management		
	Gastrointestinal Endoscopies			Plastic – Reconstructive		
	General Surgery			Plastic – Cosmetic		
	Gynecological			Podiatry		
	Neuro Surgery/Spine			Radiation Oncology/Therapy		
	Obstetrical			Urological		
	Ophthalmology/Laser Eye			Vascular		
4.	Please describe any specific cosmetic procedures being performed:					
5.	Are any other services (other than surgery) not listed above (i.e. laboratory, imaging, office visits) provided? If "Yes," list service type and amount below:				<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.	Does the Applicant perform any abortions? If "Yes," give number per year: _____				<input type="checkbox"/> Yes <input type="checkbox"/> No	
7.	What percentage of the Applicant's patients/clients are under 18 years of age? _____%					
8.	Does the Applicant have any beds used for overnight capacity? If "Yes,"				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	a. How many? _____				<input type="checkbox"/> Yes <input type="checkbox"/> No	
	b. Are any beds licensed as acute care hospital beds? If "Yes," how many? _____					
9.	Number of surgical suites/operating rooms: _____		Number of Recovery Rooms: _____			
10.	Does the Applicant provide any post-operative services? If "Yes," please describe:				<input type="checkbox"/> Yes <input type="checkbox"/> No	
11.	Please describe the provisions that have been made for the afterhours emergency: Indicate which of the following equipment is maintained at the Applicant's facility:					
	<input type="checkbox"/> EKG	<input type="checkbox"/> Oxygen	<input type="checkbox"/> Suction	<input type="checkbox"/> Defibrillator		
	<input type="checkbox"/> Crash cart with full cardiac life support capabilities and necessary IV fluids		<input type="checkbox"/> X-Ray with ability to do on premises processing			

12.	Does the Applicant have written policies and procedures that address: <ul style="list-style-type: none"> <li>a. Documentation of preoperative care, intraoperative care and postoperative care? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>b. Documentation of the performance of sponge and instrument counts in the medical record? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>c. Dictation of operative report within 24 hours of surgery? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>d. Phone call to the patient within 24 hours of discharge? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>e. Documentation of patient notification of abnormal pathology results in the medical chart? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> </ul> If "No" to any of the above, please explain:
13.	Are equipment and instruments cleaned, disinfected and sterilized at the Applicant's facility? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If "No," who provides this service?
14.	Does the Applicant have a written discharge policy in place that requires: <ul style="list-style-type: none"> <li>a. The patient be examined by a physician prior to discharge? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>b. Written instructions (original maintained in the chart) including emergency care procedures be given to the patient upon discharge? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>c. Someone other than the patient drives the patient home after the surgical procedures? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> </ul> If "No" to any of the above, please explain:
15.	Does the Applicant have a written emergency transport policy and an agreement with a local Hospital? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>  Hospital Name: _____ Hospital Address: _____ Number of miles from the Applicant's facility: _____
16.	<b>Anesthesia</b> Number of:      Anesthesiologists _____      CRNAs _____ <ul style="list-style-type: none"> <li>a. Are all anesthesiologists required to be board certified/eligible in anesthesiology? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>b. Are all CRNAs supervised by an anesthesiologist? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>c. Is a pre-anesthesia evaluation done by an anesthesiologist? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>d. Is anesthesia equipment equipped with:             <ul style="list-style-type: none"> <li>i. Oxygen analyzers? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>ii. Disconnect alarms? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> </ul> </li> <li>e. Who owns and maintains the oxygen equipment? _____</li> <li>f. Is there a written process in place for patient selection (ASA criteria or other)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>g. Is there a separate informed consent for anesthesia? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>h. Does the Applicant monitor the use of reversal agents? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span></li> <li>i. Other than anesthesiologists or CRNA's, who administers anesthesia or conscious sedation? _____</li> </ul>

**SIGNATURE AND AUTHORIZATION**

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this Supplement.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	