TDC SPECIALTY UNDERWRITERS
The Doctors Company Group

TDC Specialty Insurance Company
TDC National Assurance Company
(Stock companies owned by The Doctors Company)
(hereafter, the "Underwriter")
Servicing Address: 29 Mill Street
Unionville, CT 06085

MEDICAL FACILITIES – KETAMINE 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.

ACCOUNT INFORMATION

1 .	Applicant Name (as identified in the Liability Insurance Application for proposed insurance):		
	Doing Business As (DBA):		
	Number of Locations where services are provided:		
2.	Mailing Address:		
3.	Primary Location Address:	Street:	
		City:	State: Zip:
		County:	Telephone Number:
		Email Address:	

OPERATIONS AND ADMINISTRATION

4. Are any patients under the age of 18? ☐Yes ☐No
   If "Yes," what percentage? __________
   If "Yes," are the patient's parents/guardians involved in the patient's care at all times? ☐Yes ☐No

5. Is an informed consent process in place clearly informing patients of all uses and risks? ☐Yes ☐No
   If "Yes," how often is your informed consent process reviewed and updated? ____

Drug and Service Administration

6. Are all treatments administered by physicians, anesthesiologists, CRNAs or RNs? ☐Yes ☐No
7. Are all CRNAs and RNs administering treatment under the supervision of a physician or anesthesiologist? ☐Yes ☐No
8. Are there processes in place for monitoring patients for signs of abuse/addiction/withdrawl symptoms? ☐Yes ☐No
9. What percentage of administrations are:
   a. Intramuscular ____________%
   b. Subcutaneous ____________%
   c. Intraveneous ____________%
   d. Intranasal ____________%
   e. Oral ____________%
10. What percentage of services are performed in :
   a. Hospitals ____________%
   b. Stand alone clinics ____________%
   c. Ambulatory Surgery Center ____________%
   d. Other (describe) ____ ____________%
11. Are all treatments prescribed by a medical doctor or other professional with prescriptive authority? ☐Yes ☐No

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12.	Are emergency protocols in place for respiratory depression?	☐Yes ☐No
13.	Are reversal agents on hand at all times?	☐Yes ☐No
	Ketamine for Mental Disorders	
14.	Are all diagnoses of mental disorders made by medical professionals trained in the use of Ketamine therapy?	☐Yes ☐No
15.	Prior to prescribing ketamine for depression, have all other pharmacotherapeutic options been exhausted?	☐Yes ☐No
16.	Is there a licensed clinician on staff to evaluate behavioral risks including suicidal ideation, severe anxiety, and overall mental status prior to discharge?	☐Yes ☐No
17.	Are patients monitored for at least two hours prior to discharge?	☐Yes ☐No
18.	Are patients screened for prior issues with addiction?	☐Yes ☐No
	Ketamine for Anesthesia/Pain Management	
19.	In what percentage of procedures in your practice is ketamine used?	____________%
20.	What percentage of procedures is ketamine used for post op pain management?	____________ %

Please attach complete details about all programs offered.
Provide a copy of your current resume/experience, State License, and State Inspection

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	

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