

MEDICAL FACILITIES - MEDICAL LABORATORY 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: _____

EXPOSURES

2. Provide the total number of laboratory services and tests performed in the following categories:

Laboratory Services and Tests	Tests			Gross Receipts		
	Projected Next 12 Months	Current Year	1 Year Prior	Projected Next 12 Months	Current Year	1 Year Prior
Chemistry, Hematology, Endocrinology, Coagulation, Toxicology, Urinalysis, Immunology, Parasitology				\$ _____	\$ _____	\$ _____
Microbiology, Virology, Molecular, Diagnostics				\$ _____	\$ _____	\$ _____
Pathology, Cytology, Histology				\$ _____	\$ _____	\$ _____
Forensic Testing				\$ _____	\$ _____	\$ _____
Genetic Testing				\$ _____	\$ _____	\$ _____
Pap Smear				\$ _____	\$ _____	\$ _____
Paternity Testing				\$ _____	\$ _____	\$ _____
Reproductive Testing				\$ _____	\$ _____	\$ _____
Surgical Biopsies				\$ _____	\$ _____	\$ _____
Research				\$ _____	\$ _____	\$ _____
HIV/Aids Testing				\$ _____	\$ _____	\$ _____
Environmental Analysis				\$ _____	\$ _____	\$ _____
COVID (FDA/EUA Approved?) <input type="checkbox"/> Yes <input type="checkbox"/> No				\$ _____	\$ _____	\$ _____
Other: _____				\$ _____	\$ _____	\$ _____
Other: _____				\$ _____	\$ _____	\$ _____
Other: _____				\$ _____	\$ _____	\$ _____
TOTAL				\$ _____	\$ _____	\$ _____

OPERATIONS

3. Please provide the percentage of specimens:

a. Collected direct from patients by applicant _____ %

b. Received by applicant from outside sources: _____ %

4. List other laboratories utilized, if applicable:			
Name of Laboratory	Location (city/state)	Services Performed	Hold Harmless Agreement
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Does the Applicant's facility contract with couriers to pick up specimens? If "Yes," is there a mutual hold harmless agreement in place with all couriers?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you have a tracking protocol to ensure that all critical lab results are communicated in a timely manner?			<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are there any circumstances when test results are communicated directly to the patient?			<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Are any test results transmitted by facsimile? If "Yes," do you regularly confirm all fax numbers are valid?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Does the Applicant have electronic tracking systems for all processed specimens?			<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Is the Applicant approved and accredited by any of the following organizations			
a. Clinical Laboratory Improvement Amendment (CLIA)			<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Substance Abuse and Mental Health Services Administration (SAMHSA)			<input type="checkbox"/> Yes <input type="checkbox"/> No
c. College of American Pathologists (CAP)			<input type="checkbox"/> Yes <input type="checkbox"/> No
d. National Institute on Drug Abuse (NIDA)			<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Has the Applicant had any CLIA sanctions in the last five years? If "Yes," please explain:			<input type="checkbox"/> Yes <input type="checkbox"/> No

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	