POSITIVE PHYSICIANS
Insurance Exchange

Physical Therapy Facility Application

1. Name and Mailing Address of Facility:

_____
_____
_____
_____

2. Agent:_____

Contact Person: _____
Phone: _____
Fax: _____
E-Mail: _____
Website: _____

3. Tax ID: _____ 4. License No. _____

5. Type of Coverage: ❑ Claims-Made ❑ Occurrence

6. Requested effective date: _____

7. Retroactive date: _____

8. Limits of Liability: ❑ $500,000/$1,500,000 ❑ $1,000,000/$3,000,000

9. Number of locations: _____ , **(please attach a schedule)**

	past 12 months	projected next 12 months
10. Patient Visits	_____	_____
11. Gross receipts:	_____	_____
12. Payroll:	_____	_____

13. Hours of Operation: _____

14. Describe the type of organization and ownership:

❑ Professional Association ❑ Partnership ❑ Corporation

❑ For Profit ❑ Not for profit ❑ Community Clinic

❑ Other _____

15. Are there subsidiaries that are to be included in this coverage?
If yes, please provide the name and relationship.

_____

_____

16. List all members, partners, or stockholders. Indicate which ones work at the organization and their positions.

_____

_____

17. Is coverage desired for staff of this organization? ❑ Yes ❑ No
If yes, complete Appendix A, - Staff schedule of this application
If no, are employees required to carry their own coverage? ❑ Yes ❑ No
If yes, will the staff share the limits of insurance with the organization? ❑ Yes ❑ No
If employees maintain their own insurance, at what limits? $ _____
Do you require proof of insurance? ❑ Yes ❑ No

18. How long has the organization been in business? _____ years _____ months

19. Has the organization ever been sued or have any claims been made against it? ❑ Yes ❑ No
If yes, attach a copy of insurance company's loss run(s)

20. Name of the current professional liability insurance carriers:_____
Attach a copy of the declarations page showing, retroactive date, limits of liability, policy period, and endorsements

21. Has your professional liability insurance ever been cancelled or non-renewed? ❑ Yes ❑ No
If yes, why and when? _____

22. Are procedures in place for patient transfers to another facility in the even of an emergency: ❑ Yes ❑ No
If yes, please describe:

_____

_____

_____

23. Are medications administered? ❑ Yes ❑ No
If yes, by whom? _____

24. Do you provide any services over the internet? ❑ Yes ❑ No

25. Do you treat patients from or at a correctional facility: ❑ Yes ❑ No

26. Are physicians' services rendered? ❑ Yes ❑ No
If yes, are the physicians?
- ❑ private physicians
- ❑ contracted physicians
- ❑ employed physicians

27. Are you accredited by any nationally recognized accrediting agency? ❑ Yes ❑ No
If yes, please list the agency: _____
If no, explain why the organization didn't apply or why it was not eligible.

_____

_____

_____

28. Are you licensed by the PA Department of Health and Human Resources: ❑ Yes ❑ No

29. List names of employed personnel who are certified in CPR or ALCS.

_____

_____

_____

30. Does the organization have a written Quality Assurance/Risk Management Program? ❑ Yes ❑ No

31. Name of designated Risk Manager: _____
Phone: _____

32. Does the facility have any non-expendable medical or surgical machines or services that are used for diagnostic or treatment procedures by individual other than members of your organization? ❑ Yes ❑ No

33. Do you sell or lease any medical equipment or other product in connection with your operation? ❑ Yes ❑ No
If yes, please describe:

_____

_____

_____

34. If you lease equipment to others, do you provide maintenance on the equipment? ❑ Yes ❑ No
If yes, please describe:

_____

_____

_____

35. Do you participate as a principal investigator for any clinical trials? ❑ Yes ❑ No
If yes, do you follow FDA – approved protocols? ❑ Yes ❑ No
If yes, please explain on a separate sheet of paper.

Signature

This section must be completed by all applicants.

All of the above information is true to the best of my knowledge and belief. I understand that signing this application does not bind Positive Physicians Insurance Exchange to complete the insurance, but it is agreed that this application shall be the basis of contract should a policy be issued. I authorize release and exchange of any underwriting or claims information between all prior carriers and Positive Physicians Insurance Exchange. I understand that Positive Physicians Insurance Exchange reserves the right to reject any applicant that does not meet its underwriting standards.

Signature of Applicant _____ Date _____

Officer of Organization

Appendix A – Staff Schedule

List all professional staff including members, partners, and shareholders (Physicians, etc.)

Name	License Number	Specialty or Position	Date of Hire	Employee or Independent Contractor	Average # of hours worked per week

For all professional staff, please attach certificates of insurance, declaration page, loss history and CV.

List all Allied Professionals (RN, LPN, Physical Therapist, PT – Tech, etc.)

Name	License Number	Specialty or Position	Date of Hire	Employee or Independent Contractor	Average # of hours worked per week

For all professional staff, please attach certificates of insurance, declaration page, loss history and CV.

List all other staff

Name	Position	Date of hire	Average # of hours per week

Signature: _____ Date: _____