



Atlantic Specialty Lines, Inc.

ALLIED MEDICAL - MEDICAL IMAGING CENTERS

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

Applicant Name: _____

1. Service is provided for: Hospitals _____% Nursing Homes _____%
Physicians' Offices _____% Industrial Facilities _____%
Other _____% (describe) _____

2. Number of tests performed last 12 months _____
Anticipated next 12 months _____
Number of patient contacts last 12 months _____
Anticipated next 12 months _____

3. For medical imaging centers, indicate number of tests in each category:
MRIs _____ CT scans _____ Mammograms _____
Diagnostic x-rays _____ Ultrasounds _____
Other (describe) _____

4. Are tests/film results interpreted or diagnosed by applicant? No Yes
Are tests/film results interpreted or diagnosed by third party under contract to applicant to provide said service? No Yes
If "Yes," in either situation, who diagnoses/interprets? _____

5. Name and qualifications of Medical Director* _____
Name and qualifications of Medical Review Officer* (MRO) _____

***Attach Curriculum Vitae (C.V.)**

6. Specimens: _____% collected direct from patient by applicant; describe types of specimens collected: _____
_____% received by applicant from outside sources.

7. Is applicant involved in any: **(If "Yes," attach full description)**

a. Services open to the public (health fairs, shopping mall exhibits, etc.)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
b. Blood banking or cross matching	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c. Medical, genetic, AIDA or drug research	<input type="checkbox"/> No	<input type="checkbox"/> Yes
d. Manufacturing, dispensing or testing pharmaceuticals	<input type="checkbox"/> No	<input type="checkbox"/> Yes
e. Use of injected or ingested materials	<input type="checkbox"/> No	<input type="checkbox"/> Yes
f. Use of any radioactive material other than normal x-ray equipment	<input type="checkbox"/> No	<input type="checkbox"/> Yes
g. Therapy or treatment procedures	<input type="checkbox"/> No	<input type="checkbox"/> Yes
h. Environmental analyses	<input type="checkbox"/> No	<input type="checkbox"/> Yes
i. Manufacturer and/or sell laboratory equipment or supplies, reagents or software	<input type="checkbox"/> No	<input type="checkbox"/> Yes
j. Intravenous transfusions of blood or in the procurement of blood or blood products	<input type="checkbox"/> No	<input type="checkbox"/> Yes
k. Illegal drug testing: If "Yes," _____% of your gross receipts	<input type="checkbox"/> No	<input type="checkbox"/> Yes
l. Testing for AIDS; If "Yes," _____% of your gross receipts	<input type="checkbox"/> No	<input type="checkbox"/> Yes
m. Is Cardiac Catheterization performed at your facility	<input type="checkbox"/> No	<input type="checkbox"/> Yes

8. Does applicant provide any services under contract? No Yes
If "Yes," attach explanation.
9. Is the applicant in the employ of any federal government entity? No Yes
If "Yes," attach explanation.
10. Does the applicant advertise its professional services in any manner (other than a simple listing in a telephone directory)? No Yes
If "Yes," attach detailed explanation and a copy of ALL of the advertisements.
11. Is the applicant associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? No Yes
If "Yes," attach detailed explanation and a copy of ALL of the advertisements.
12. Has the applicant or any of its employees ever: **(If "Yes," attach full description).**
- Been the subject of disciplinary or investigatory proceedings or been reprimanded by an administrative or governmental agency, hospital or professional association? No Yes
 - Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? No Yes
13. Is the applicant:
- Licensed in accordance with all applicable state and federal laws? No Yes
 - Approved by National Institute on Drug Abuse (NIDA) if lab is involved in drug testing? No Yes
- If "No," to either of the above, provide detailed explanation.**
- Has the applicant or any of its employees had any professional license refused, suspended, revoked, renewal refused or accepted only on special terms or has applicant or any of its employees voluntarily surrendered any professional license? No Yes
If "Yes," provide detailed explanation.
14. Is your facility owned by a M.D.? No Yes
If "Yes," owner name(s) _____
If "Yes," indicate % of total services to the owner's patients represent _____%
15. Describe the referral source(s) by which patients are directed to the entity: _____
16. Does your facility participate in any clinical trials or experimental procedures, equipment or product testing? No Yes
If "Yes," attach separate sheet describing the facility's involvement and a copy of the protocol, and any contracts involving same.
17. Does your facility own or operate any mobile diagnostic/ imaging units? No Yes
If "Yes," indicate the manufacturer/ uses/sites used, and the gross receipts from each unit: _____

18. Is a physician present to administer/supervise the injection of such substances? No Yes
19. Describe the protocol for treating adverse reactions: _____

20. Describe the patient screening process your facility utilizes for pregnancy, pacemakers, artificial valves, etc. _____

21. Does your facility require the professional staff to be CPR trained? No Yes
22. Who performs the following in your facility?
- Calibration of diagnostic equipment? Contractor Employee
 - Services/Maintains diagnostics equipment? Contractor Employee
- If contractors perform either function, attach copy of contract. If employee, advise position and qualifications: _____

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23. Has there been any equipment failures/problems resulting in injury to a patient? No Yes
If "Yes," describe event(s) and steps taken to avoid recurrence: _____
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24. Do you have policies and procedures in place to report all applicable problems with medical devices to the Federal Drug Administration? No Yes
25. Are logs kept of all servicing, maintenance, and calibration of precision instruments? No Yes

* Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

* not applicable in all states

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

Applicant's Signature

Sub-Producer

Title/Date

Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.