LOVELAND & SMART INSURANCE SERVICES, INC

HOSPITAL/HEALTH CARE SUPPLEMENTAL APPLICATION

NAME OF APPLICANT:_____

_____

COMPLETE THE FOLLOWING FOR EMERGENCY CONVEYANCES OPERATED OR OCCUPIED BY EMPLOYEES:

TYPE OF CONVEYANCE	OPERATED BY EMPLOYEES		NOT OPERATED BY EMPLOYEES	
	NO. OF UNITS	AVG. NO. OF EMPLOYEES OCCUPYING	NO. OF UNITS	AVG. NO. OF EMPLOYEES OCCUPYING
☐ AMBULANCE	_____	_____	_____	_____
☐ FIXED WING AIRCRAFT*	_____	_____	_____	_____
☐ HELICOPTER*	_____	_____	_____	_____
☐ OTHER	_____	_____	_____	_____

**** AIRCRAFT SUPPLEMENTAL QUESTIONNAIRE MUST BE COMPLETED.***

Is applicant in compliance with all OSHA standards with respect to handling of and contact with ethylene oxide? ☐ Yes ☐ No

If "No," explain. _____

Are you accredited by JCAHO or a similar governing entity? ☐ Yes ☐ No

Is applicant in compliance with CDC's and OSHA's standards for blood-borne pathogens and infectious disease? ☐ Yes ☐ No.

If "No," explain. _____

_____

Are written and enforced loss control procedures in effect with regard to the following?

COMMUNICABLE DISEASE: ☐ YES ☐ NO

NEEDLE STICKING AND REPORTING DEADLINES: ☐ YES ☐ NO

LIFTING: ☐ YES ☐ NO

HANDLING OF BODILY FLUIDS: ☐ YES ☐ NO

RADIATION EXPOSURES: ☐ YES ☐ NO

Explain any "No" answers._____

_____

Provide the following patient/resident population information:

Patients/Residents	**Previous 12 Months**
HIV and AIDS only	_____
Total (including HIV and AIDS)	_____
Number of emergency room patients annually:	_____

Is applicant involved in any of the following AIDS or HIV related areas?

Specialization in the treatment of AIDS patients ☐ YES ☐ NO

AIDS Research ☐ YES ☐ NO

Clinical testing for the HIV virus ☐ YES ☐ NO

Explain any "Yes" responses _____

_____

Does applicant provide home health care? ☐ YES ☐ NO If "Yes", complete the following.

DESCRIPTION OF DUTIES	NO. OF EMPLOYEES	AVERAGE PER EMPLOYEE	
		NO. OF VISITS PER MONTH	MILES TRAVELED PER MONTH
RN/LPN	_____	_____	_____
NURSE'S AIDE	_____	_____	_____
HOUSEKEEPING	_____	_____	_____
AIDS PATIENT CARE	_____	_____	_____
THERAPISTS	_____	_____	_____
OTHER	_____	_____	_____

Does applicant intend to have this insurance extend to cover non-compensated volunteer employees, if allowed by their state? ☐ YES ☐ NO **If "Yes", complete the following:**

Description of duties	No. of Volunteers	Total annual hours worked
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is the Hospital designated as a "First Responder" in the event of a biological, chemical, or radiological attack? (I.e. Hazmat suits, Biocontainment rooms, etc.) ☐ YES ☐ NO **If "Yes", please explain:**

_____

_____

Does hospital have parking underneath or within building? ☐ YES ☐ NO

_____ _____ _____

Date ***Applicant's Signature*** ***Title***

_____

Print Applicant's Signature