James River Insurance Company

ALLIED HEALTHCARE - MEDICAL IMAGING CENTERS
SUBMIT WITH ALLIED HEALTHCARE 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. Name and qualifications of Medical Director*_____
   Name and qualifications of Medical Review Officer* (MRO)_____
   ***Attach Curriculum Vitae (C.V.)**

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

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

a. Services open to the public (health fairs, shopping mall exhibits, etc.) [ ] No [ ] Yes

b. Blood banking or cross matching [ ] No [ ] Yes
c. Medical, genetic, AIDA or drug research [ ] No [ ] Yes
d. Manufacturing, dispensing or testing pharmaceuticals [ ] No [ ] Yes
e. Use of injected or ingested materials [ ] No [ ] Yes
f. Use of any radioactive material other than normal x-ray equipment [ ] No [ ] Yes
g. Therapy or treatment procedures [ ] No [ ] Yes
h. Environmental analyses [ ] No [ ] Yes
i. Manufacturer and/or sell laboratory equipment or supplies, reagents or software [ ] No [ ] Yes
j. Intravenous transfusions of blood or in the procurement of blood or blood products [ ] No [ ] Yes
k. Illegal drug testing: **If "Yes", _____ % of your gross receipts** [ ] No [ ] Yes
l. Testing for AIDS; **If "Yes", _____% of your gross receipts** [ ] No [ ]Yes
m. Is Cardiac Catheterization performed at your facility [ ] No [ ] Yes

7. Does applicant provide any services under contract? [ ] No [ ]Yes
If "Yes", attach explanation.

8. Is the applicant in the employ of any federal government entity? [ ] No [ ] Yes
If "Yes", attach explanation.

9. Does the applicant advertise its professional services in any manner (other than a simple listing in a telephone directory)? **If "Yes",** [ ] No [ ] Yes
attach detailed explanation and a copy of ALL of the advertisements.

10. 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.

11. Has the applicant or any of its employees ever: **(If "Yes", attach full description).**
a. Been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? [ ] No [ ] Yes
b. Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? [ ] No [ ] Yes

12. Is the applicant:
a. Licensed in accordance with all applicable state and federal laws? [ ] No [ ]Yes
b. 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.

13. 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. 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?_____
_____
_____

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

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

26. 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:_____
_____

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

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

_____
Title/Date

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