



BLOOD BANK

LOCATION APPLICATION

This is a supplemental application. Please complete a separate application for each facility where whole blood or blood components are processed, tested, stored or distributed. A separate application is not required for each blood collection center (i.e., a location, mobile or stationary) that *only* procures whole blood or blood components for transportation to a blood bank for processing, testing, storage and distribution. If a question does not apply to the facility, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. Your signature is required on page 12.

In addition to the completed application, please provide the following items:

- Copies of the facility's letterhead(s) and advertisements

SECTION I IDENTIFYING INFORMATION

Name of Facility				
Address	City	County	State	Zip Code
Telephone Number	Fax Number		Website Address	
Location Type:	<input type="checkbox"/> Freestanding – Hospital Satellite <input type="checkbox"/> Freestanding – Independent <input type="checkbox"/> Hospital-based <input type="checkbox"/> Physician's Office <input type="checkbox"/> Mobile Unit <input type="checkbox"/> Other (specify): _____			

1. Please describe the ownership of the facility. If there is more than one owner, attach an organizational chart that identifies the facility's ownership structure and each owner's percentage of ownership interest:

SECTION II COVERAGE/INSURANCE INFORMATION

Facility Requested Effective Date (the date you wish coverage to begin)

NOTE: Please complete this question only if this is an application to add a new location to an existing NORCAL policy. NORCAL should receive the application at least thirty days before the Requested Effective Date.

_____ 12:01 a.m. Local Time
 Month Day Year

Facility Prior Acts Coverage (check one)

If approved, Prior Acts Coverage, also known as Retroactive Coverage or Nose Coverage, would provide protection for claims that 1) are first reported to NORCAL after the Policy Effective Date with NORCAL and the effective date of coverage for this location and 2) arose out of acts or omissions occurring on or after the Policy and location Retroactive Dates and before the termination or Expiration Date of that policy and location. The Retroactive Date is the earliest date on which a medical incident or occurrence may occur and for which coverage may be afforded under the NORCAL policy. Prior Acts Coverage provides an alternative to purchasing Tail Coverage from your current carrier, if applicable. This coverage does not apply to the optional Health Care General Liability Insurance. **NORCAL does not automatically provide Prior Acts Coverage.**

- The facility wishes to apply for Prior Acts Coverage. Additional premium will be charged if this coverage is approved. Unless you are notified by NORCAL that your request for Prior Acts Coverage has been approved, do not forfeit your right to purchase Tail Coverage from your current carrier. (Please identify the Requested Retroactive Date below and complete the Prior Acts Coverage section on page 11):
- The facility does **not** wish to apply for Prior Acts Coverage. It is understood that if the facility does not obtain Prior Acts Coverage, it will have no coverage with NORCAL for claims arising from any acts or omissions that occurred prior to the effective date of coverage for this location.

Facility Requested Retroactive Date

_____ 12:01 a.m. Local Time
 Month Day Year

NOTE: The Retroactive Date, if specified, must be the same as the Retroactive Date of your current policy.

Facility Professional Liability Insurance History

NOTE: Please complete the questions in this section only if one of the following applies:

- This is an application to add a new location to an existing NORCAL policy and it is not a brand new facility, or
- The facility's professional liability insurance history is different from the organization's professional liability insurance history as indicated on the Health Care Facilities Policy Application

1. Please complete the following regarding all professional liability insurance maintained by the facility during the past ten years, beginning with the most current. Please photocopy this page if additional space is needed.

Name of Insurer	Coverage Dates (month/day/year)	Deductible or Self-insured Retention?	Policy Type	If Claims Made, Check One
	From: To:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify type: _____ Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____
	From: To:	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify type: _____ Amount: \$ _____	<input type="checkbox"/> Claims Made <input type="checkbox"/> Occurrence <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tail Coverage purchased <input type="checkbox"/> Prior Acts Coverage purchased from subsequent insurer <input type="checkbox"/> Other: _____

2. If any one of the insurance coverages identified above was Claims Made Coverage, and the group/organization did not purchase Tail Coverage or Prior Acts Coverage, please explain in the Remarks section on page 11.

SECTION III HEALTH CARE PROVIDERS

1. Please provide the name and designation of the medical director and laboratory director:

Medical Director: _____

Laboratory Director: _____

2. Please identify the number of individuals in the following categories who provide services in or on behalf of the facility.

Provider Type	Partner/ Shareholder	Employee	Independent Contractor	Staff Member (excluding those in other categories)	Other: _____ _____
Physician/Surgeon					
Nurse Practitioner					
Physician Assistant					
Cytotechnologist					
Laboratory Bioanalyst					
Laboratory Technician/Technologist					
Phlebotomist					
Registered Nurse					
Other: _____					
Other: _____					

3. Does the facility lease any health care personnel from other organizations or individuals (e.g., temporary employment agencies)?
 Yes No

If yes, please provide a copy of the contract(s).

4. Are all personnel who provide professional health care services in or on behalf of the facility licensed and/or certified as required by state law for the services they provide? Yes No

If no, please explain:

5. Please answer the following regarding those individuals who render services in or on behalf of the facility but who are **not** employees:

- a. Are they required to maintain professional liability insurance with limits of liability of at least \$1 million per claim/\$3 million annual aggregate? Yes No
- b. Are they required to provide proof of professional liability insurance at least annually? Yes No

If you answered no to question 5a or 5b, please explain:

6. Please check all that apply to individuals who are rendering services in or on behalf of the facility but who are not owners or employees:

- | | | |
|---|------------------------------|-----------------------------|
| Share in the facility's profits and/or overhead expenses? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Use the facility's letterhead? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Use the facility's advertisements? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bill under the facility's name? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you answered yes to any one of the above, please identify the name and designation of each individual and the applicable common action(s) pertinent to him or her:

SECTION IV ACCREDITATION, CERTIFICATION AND LICENSURE

1. Has the facility ever been denied accreditation, certification and/or licensure or has its accreditation, certification and/or licensure ever been suspended or revoked? Yes No

If yes, please explain and provide a copy of the results of the inspection(s) that led to the denial, suspension or revocation:

2. Please provide copies of the following items for the facility:

- FDA Blood Establishment Registration and Product Listing
- Federal biologics license and state license(s)
- CLIA certificate
- Most recent federal inspection report and the responses to any contingencies and/or regarding any deficiencies

If the facility is not currently licensed by the FDA and/or by the state(s) in which it operates, please explain:

3. Is the facility currently accredited? Yes No

If yes, please identify each agency, provide proof of accreditation, a copy of the agency's most recent inspection report and the facility's responses to any contingencies and/or deficiencies:

AABB Other: _____

If no, please indicate if the facility is scheduled for an inspection, and if so, specify with which agency and the date of the inspection:

SECTION V BLOOD COLLECTION

1. Please complete the following table regarding the *estimated* number of blood donations to be made in the facility during the current year and the *actual* number of blood donations made in the facility during the applicable prior years. Please provide the numbers for each calendar year (January through December).

NOTE: If a mobile unit is used to collect blood that is transported to the facility, please include those donations in your totals.

Current Year Estimate	First Prior Year	Second Prior Year	Third Prior Year	Fourth Prior Year	Fifth Prior Year

2. Is blood transported to this facility from any other location(s), excluding mobile units? **Yes** **No**

If **yes**, please complete the following for each location. Please photocopy this page if additional space is needed.

Name and Address	Is the Location Owned By Your Blood Bank?
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you indicated that any one of the above locations is not owned by your blood bank, please explain and provide proof of professional liability insurance for each location:

3. What percentage of the facility's blood is collected utilizing mobile units? _____%

If any of the facility's blood is collected utilizing mobile units, please complete the following questions:

- a. Please identify the number of mobile units and the state(s) in which the mobile units operate:

- b. Is each mobile unit owned by the blood bank? **Yes** **No**

If **no**, please explain and provide proof of professional liability insurance for each mobile unit not owned by your blood bank:

4. Please identify the minimum age required for individuals who donate blood in the facility or any one of its blood collection centers:

Without Parent Consent: _____ With Parent Consent: _____

5. Please identify who performs the skin punctures and venipuncture for the purpose of collecting the blood:

Laboratory Bioanalyst Laboratory Technician/Technologist LVN/LPN Phlebotomist Registered Nurse
 Other (specify): _____

SECTION VI BLOOD TESTING

1. Does the facility provide laboratory services on-site? **Yes** **No**

2. If laboratory services are provided on site, please answer or provide the following:

a. Please identify which one of the following currently applies regarding the facility's CLIA certification:

Certificate of Compliance Certificate of Accreditation Certificate of Waiver Certificate of Registration

Certificate for Provider-Performed Microscopy Procedures

No Certificate (please explain): _____

b. If the facility has a certificate of registration, when is the facility scheduled to be inspected? _____

c. Are the laboratory services performed in the facility limited to those authorized by its CLIA certification? **Yes** **No**

If no, please explain:

d. Does the facility provide laboratory services for other organizations? **Yes** **No**

If yes, please identify the organization(s), the laboratory services provided and how often this occurs, and provide proof of each organization's professional liability insurance:

3. How does the facility notify donors of abnormal findings and test results?

SECTION VII BLOOD TRANSFUSIONS AND THERAPEUTIC PROCEDURES

1. Are any one of the following performed in or on behalf of the facility:

Therapeutic Apheresis Yes No Therapeutic Phlebotomy Yes No Blood Transfusions Yes No

NOTE: Please complete the remaining questions in this section only if you answered yes to any one of the above.

2. Please complete the following table regarding the *estimated* number of therapeutic procedures and/or blood transfusions to be performed in the facility during the current year and the *actual* number of each performed in the facility during the applicable prior years. Please provide the numbers for each calendar year (January through December).

Current Year Estimate	First Prior Year	Second Prior Year	Third Prior Year	Fourth Prior Year	Fifth Prior Year

3. Please complete the following regarding these procedures:

a. Please identify who performs the procedures and where they are performed:

Procedure	Who Performs It?	Where Is It Performed?
Therapeutic Apheresis	<input type="checkbox"/> Physician <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> This Facility <input type="checkbox"/> Other (specify): _____
Therapeutic Phlebotomy	<input type="checkbox"/> Physician <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> This Facility <input type="checkbox"/> Other (specify): _____
Blood Transfusions	<input type="checkbox"/> Physician <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> This Facility <input type="checkbox"/> Other (specify): _____

b. Are the procedures ever performed without having been ordered by a physician? Yes No

If yes, please identify the procedure(s), explain under what circumstances this occurs, how often it occurs and the designation(s) and qualifications of those individuals permitted to order it:

c. Is a medical record created and maintained for each patient who undergoes a therapeutic procedure or blood transfusion? Yes No

d. Is it a requirement that procedure notes be dictated on the day of the procedure? Yes No

If you answered no to question 3c or 3d, please explain:

SECTION VIII MISCELLANEOUS

1. Does the facility distribute any blood products to a state other than the state in which this facility is located? Yes No

If yes, please identify the facility(ies) and state(s) to which these products are distributed and how often this occurs:

2. Are the services provided or procedures performed on behalf of the facility limited to blood banking services and procedures?
 Yes No

If no, please explain:

3. Are any drugs, pharmaceuticals, devices or equipment used, administered, distributed or prescribed in or on behalf of the facility that are disapproved or not yet approved by the United States Food and Drug Administration (FDA) for treatment of human beings?
 Yes No

If yes, please explain:

4. Are all medications stored in a secure location and handled in compliance with federal, state and local laws and regulations?
 Yes No

5. Is there an emergency power source available? Yes No

6. Does the facility comply with all federal, state and local laws and regulations regarding the disposal of hazardous waste material?
 Yes No

7. Is all facility equipment maintained, tested and inspected according to manufacturers' guidelines and federal, state and local laws and regulations? Yes No

If you answered no to any one of questions 4 – 7, please explain:

SECTION IX RISK MANAGEMENT

1. Does the facility have a formal risk management program? Yes No

a. If yes, who (name and title) is responsible for the risk management program?

b. If no, please explain:

Credentialing

1. Does the facility have a formal process to credential its health care providers? **Yes** **No**

a. **If yes**, please identify who performs the initial credentialing (e.g., employee, hospital, outside company):

b. **If no**, please explain:

2. Does the facility evaluate the following when credentialing its health care providers?

Claim History **Yes** **No** **If yes**, source(s) used: _____

Hospital Privileges **Yes** **No**

Employment History **Yes** **No** **If yes**, source(s) used: _____

Education History **Yes** **No** **If yes**, source(s) used: _____

Felony/Misdemeanor History **Yes** **No** **If yes**, source(s) used: _____

Medical/Dental/Nursing
and Narcotic Licenses **Yes** **No** **If yes**, source(s) used: _____

If you answered no to any one of the above, please explain:

3. Does the facility use the same credentialing procedures to credential independent contractors and locum tenens health care providers? **Yes** **No**

If no, please describe the credentialing process used:

4. How often are the facility's health care providers recredentialed?

Records

1. Does the facility currently use electronic medical records? **Yes** **No**

If yes:

a. Who is the vendor? _____

b. How often are the electronic files backed up? _____

c. Who backs up the files? _____

d. Are the backed-up files stored at an off-site location? **Yes** **No**

If you answered no to question 1d, please explain:

e. Are all systems (e.g., inpatient, outpatient, billing, scheduling) electronic? **Yes** **No**

If you answered no to question 1e, how are the different systems coordinated?

2. How are record-keeping deficiencies identified and handled?

SECTION X SUPPLEMENTAL QUESTIONS

If you answer YES to any one of the following questions, you must provide a detailed, written narrative (including, but not limited to, date of occurrence, reason for occurrence and the resolution) and pertinent documentation (e.g., medical board documents, letters from a hospital, diversion program and/or treating physician, etc.).

1. Has any governmental agency **ever** investigated, placed on probation, suspended or taken any action against the facility? Yes No
2. Have the facility's membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), **ever** been denied, restricted, suspended, revoked, not renewed, voluntarily or involuntarily surrendered, subject to probationary terms or conditions, or otherwise investigated or limited in any way, for possible incompetence, improper professional conduct or breach of conduct, or is any such action pending? Yes No
3. Has the facility **ever** surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? Yes No
4. Has the facility or any facility member **ever** been accused of sexual misconduct? Yes No
5. Do you know if any individual who works on the facility's behalf has a prior history or propensity for sexual misconduct? Yes No

SECTION XI CLAIMS HISTORY

Other than any claims, incidents, etc. that have already been reported on the organization's main application, if applicable:

1. Within the past ten (10) years, has a malpractice claim or suit been brought against the facility, or has the facility been notified of its involvement in a malpractice claim or suit, either directly or indirectly? Yes No
2. Is the facility aware of any medical incident or accident, conduct, circumstance or occurrence that might reasonably be expected to give rise to a claim or suit against the facility, directly or indirectly, even if you believe the claim or suit would be without merit?
 Yes No

If you answered yes to question 1 or 2, please complete a Claim Information Form on page 13 for each applicable claim, suit, incident, conduct, etc.

SECTION XII PRIOR ACTS COVERAGE

NOTE: If the facility is not applying for Prior Acts Coverage, please skip this section.

Please ensure that your answers to the following questions reflect the facility's practice as it was during the Prior Acts Period.

1. Since the Requested Retroactive Date, has there been a change in the legal structure of the facility (for example, change in owners, type of entity)? **Yes** **No**

If **yes**, please explain and identify the appropriate dates:

2. Since the Requested Retroactive Date, have there been any material changes in the facility's practice (for example, types of procedures performed or services provided)? **Yes** **No**

If **yes**, please explain and identify the appropriate dates:

REMARKS

Beneath "Question Number," please indicate the question number and, if applicable, the letter (e.g., 2, 3b). Please photocopy this page if additional space is needed.

Page Number	Section Number	Question Number	Remarks
-------------	----------------	-----------------	---------

Please provide any additional information material to the risk that has not otherwise been addressed in this application:

FOR CALIFORNIA AND RHODE ISLAND FACILITIES ONLY

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to the facility's coverage. I agree to notify NORCAL Mutual Insurance Company immediately if the facility's practice changes in any way and of any change in the information contained on this application.

Signature of Authorized Representative

Date

Print Name

FOR ALASKA FACILITIES ONLY

I represent the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to the facility's coverage. I agree to notify NORCAL Mutual Insurance Company immediately if the facility's practice changes in any way and of any change in the information contained on this application.

Signature of Authorized Representative

Date

Print Name

CLAIM INFORMATION FORM

Name of Patient: _____ Gender: Male Female

Age of Patient (at time of treatment): _____

Name of Claimant (if different than patient): _____

Location of Incident: _____

Allegation Against the Facility: _____

Facility Member Defendants: _____

Non-Facility Member Defendants: _____

Date Incident or Claim Was Reported to the Insurance Company: _____

Name of Insurance Company: _____

Disposition or Current Status of the Incident, Claim or Suit Against the Facility:

Open

- Incident has been reported but claim or suit has not been filed
- Claim or suit has been filed and is awaiting start of arbitration, mediation, trial, etc.
- Claim or suit is currently in arbitration or mediation or is being tried in court
- Settlement has been made or judgment returned but remains open

Closed

Date Closed (month/day/year): _____

- Incident was reported but claim or suit was not filed
- Claim or suit was filed but was dismissed or dropped before trial
- Claim or suit was filed but settlement was made
- Verdict or judgment was made in the entity's favor
- Verdict or judgment was made in favor of the plaintiff

Total loss payment amount (if payment made): _____

Amount paid on the facility's behalf: _____

Total verdict amount (if different than total loss payment amount): _____

