URGENT CARE CENTER
LOCATION APPLICATION

This is a supplemental application. Please complete a separate application for each facility. 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 13.

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

- Copies of the facility's letterhead(s) and advertisements
- A list of all procedures performed and services provided in the facility
- **A roster of the individuals who provide services in or on behalf of the facility (refer to Section III for specifics)**

SECTION I IDENTIFYING INFORMATION

Name of Facility				
Address	City	County	State	Zip Code
Telephone Number	Fax Number	Website Address		

Location Type: ☐ Freestanding – Hospital Satellite ☐ Freestanding – Independent ☐ Hospital-based
☐ Physician's Office ☐ Other (specify): ___________________________________

Hours of Operation:	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

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:

   ____

   ____

2. Please describe the facility's scope of practice:

   ____

   ____

3. Please explain how the facility is held out to the public (for example, urgent care facility or extended hours office):

   ____

   ____

4. Are the services provided in the facility limited to a specific physician or medical group? ☐ **Yes** ☐ **No**

   If yes, please identify the physician or medical group:

   ____

   ____

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 12):

☐ 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:	☐ Yes ☐ No If yes, specify type: ________________________ Amount: $______________	☐ Claims Made ☐ Occurrence ☐ Other: _______________	☐ Tail Coverage purchased ☐ Prior Acts Coverage purchased from subsequent insurer ☐ Other: __________________
	From: To:	☐ Yes ☐ No If yes, specify type: ________________________ Amount: $______________	☐ Claims Made ☐ Occurrence ☐ Other: _______________	☐ Tail Coverage purchased ☐ Prior Acts Coverage purchased from subsequent insurer ☐ 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 12.

SECTION III HEALTH CARE PROVIDERS

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

____

____

2. Does the medical director provide professional health care services in the facility in addition to his/her administrative duties?
☐ **Yes** ☐ **No**

3. Please provide a roster of all individuals who provide services in or on behalf of the facility. The roster must include the following items for each individual:

- Name and designation
- Type of provider (i.e., physician, nurse practitioner, registered nurse, etc.)
- Whether the individual is a partner/shareholder, employee, independent contractor or staff member

4. 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).

5. 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:

____

____

6. 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 6a or 6b, please explain:

____

____

7. 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? ☐ **Yes** ☐ **No**
   Use the facility's letterhead? ☐ **Yes** ☐ **No**
   Use the facility's advertisements? ☐ **Yes** ☐ **No**
   Bill under the facility's name? ☐ **Yes** ☐ **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, has its accreditation, certification and/or licensure ever been suspended or revoked or has it been subject to probationary terms or conditions? ☐ **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. Is the facility currently licensed by a state health agency? ☐ **Yes** ☐ **No**

   If yes, please provide a copy of the license.

3. Is the facility currently accredited? ☐ **Yes** ☐ **No**

   If yes, please identify each agency and 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:

   ☐ JCAHO ☐ AAAASF ☐ AAAHC ☐ IMQ ☐ Other: ____

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

   ____

   ____

SECTION V SERVICES AND PROCEDURES

1. Please complete the following table regarding the *estimated* number of patient visits in the facility during the current year and the *actual* number of patient visits 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

2. Please identify the type(s) of anesthesia used in the facility. Please use the American Society of Anesthesiologists' current definitions for the levels of sedation/analgesia:

   ☐ Local/Topical Anesthesia ☐ Regional Anesthesia (excluding spinal/epidural) ☐ Spinal/Epidural
   ☐ Moderate Sedation ☐ Deep Sedation ☐ General Anesthesia

3. What percentage of the clinic's patients are walk-ins requiring urgent or emergency care? _____%

4. For what percentage of the patients treated in the facility do facility personnel serve as the primary care provider? _____ %

5. What percentage of the patients treated in the facility continue their care with facility personnel following their initial visits? _____ %

6. Do facility personnel ever follow patients after they have been admitted into the hospital? ☐ **Yes** ☐ **No**

   If yes:

   a. Please identify how often this occurs and the nature and scope of the services provided by facility personnel after the patients have been admitted (i.e., attending, assisting in surgery, primary surgeon):

   ____

   ____

   b. Is the hospital care provided by facility personnel limited to patients who have been treated in your facility? ☐ **Yes** ☐ **No**

   If no, please explain:

   ____

   ____

7. Do facility personnel perform or provide the following in or on behalf of the facility?

   Cosmetic Procedures ☐ **Yes** ☐ **No**
   Emergency Care ☐ **Yes** ☐ **No**
   Obstetrical Services (including prenatal care) ☐ **Yes** ☐ **No**

   If you answered yes to any one of the above, please explain, identify the percentage of the facility's practice devoted to the applicable procedure/service and identify who performs the procedures/provides the services:

   ____

   ____

8. Are exercise EKGs performed in the facility? ☐ **Yes** ☐ **No**

   If yes:

   a. Is the patient's blood pressure monitored? ☐ **Yes** ☐ **No**

   b. Is the patient's heart rhythm monitored via an EKG monitor? ☐ **Yes** ☐ **No**

   If you answered no to question 8a or 8b, please explain:

   ____

   ____

9. Does any individual other than a physician, nurse practitioner, physician assistant or registered nurse perform the initial triage and screening of an individual who presents to the facility? ☐ **Yes** ☐ **No**

   If yes, please identify the individual(s), along with his or her designation(s) and qualifications:

   ____

   ____

10. Do any nonphysician personnel provide professional health care services in the facility when a physician is not on-site? ☐ **Yes** ☐ **No**

    If yes, please provide the following in the Remarks section on page 12:

    - The name and designation of each nonphysician and the type(s) of services provided by him or her when a physician is not on-site
    - The type of supervision provided and by whom, and whether a physician is always on call
    - If a physician is on call, the maximum amount of time it would take him or her to make it to the facility
    - The number of hours per week that the facility does *not* have a physician on-site during its hours of operation

SECTION VI ANCILLARY SERVICES

1. Does the facility provide any of the following services on-site?

   Pharmaceutical ☐ **Yes** ☐ **No** Laboratory ☐ **Yes** ☐ **No** Radiology ☐ **Yes** ☐ **No**

   If yes, please answer the remaining questions in this section.

2. Does the facility maintain separate professional liability insurance for any one of these services? ☐ **Yes** ☐ **No**

   If yes, please identify the service(s) for which the separate professional liability insurance is maintained and provide proof of the insurance:

   ____

   ____

3. Are the services provided only for individuals who will undergo surgery or a procedure in the facility? ☐ **Yes** ☐ **No**

   If no, please explain:

   ____

   ____

4. 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 for Provider-Performed Microscopy Procedures ☐ Certificate of Registration
☐ No Certificate (please explain): ____

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

c. Please provide a copy of the facility's laboratory license.

d. Are the laboratory services provided by the facility limited to those authorized by its CLIA certification? ☐ **Yes** ☐ **No**

If no, please explain:

____

____

5. If radiology services are provided on-site, does any one other than a radiologist interpret the images? ☐ **Yes** ☐ **No**

If yes, please indicate who interprets the images, the type(s) of images interpreted by nonradiologists and whether the images are overread by a radiologist:

____

____

If a radiologist does not overread the images interpreted by a nonradiologist, does the individual who interpreted the image render a formal report? ☐ **Yes** ☐ **No**

If no, please explain:

____

____

SECTION VII TELEMEDICINE

Telemedicine is defined as "the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video or data communications. Neither a telephone conversation nor an electronic mail message between a licensed health care practitioner and another licensed health care practitioner and/or between a licensed health care practitioner and a patient constitute telemedicine."

1. Does the facility:

a. Provide telemedicine services? ☐ **Yes** ☐ **No**

b. Receive telemedicine services? ☐ **Yes** ☐ **No**

If you answered yes to either of the above, please explain and provide a copy of the contract(s):

____

____

SECTION VIII MISCELLANEOUS

1. Please identify the means used to admit patients into the hospital should the need arise:

   ☐ Transfer agreement with hospital ☐ Facility physicians with admitting privileges ☐ Call 911
   ☐ Other (specify): ____

   If the facility has a transfer agreement with a hospital(s), please identify each hospital and the facility's distance to it (in miles):

   ____

   ____

2. What is the maximum response time (in minutes) to the facility for emergency medical services (EMS)? ____________________

3. What is the maximum transport time (in minutes) from the facility to the nearest emergency department? ____________________

4. Please identify if health care providers certified in the following are *always* on-site during the facility's hours of operation:

   Basic Life Support? ☐ **Yes** ☐ **No** Pediatric Basic Life Support? ☐ **Yes** ☐ **No**

   Advanced Cardiac Life Support (ACLS)? ☐ **Yes** ☐ **No** Pediatric Advanced Life Support (PALS)? ☐ **Yes** ☐ **No**

   If you answered no to all of the above, please identify the minimum requirements for health care providers:

   ____

   ____

5. Does the facility maintain a crash cart that is immediately available to each patient in the facility at all times and that is equipped with at least cardiac drugs (needed to comply with current ACLS standards), basic airway and IV access equipment, a cardiac monitor/defibrillator *and* supplemental oxygen? ☐ **Yes** ☐ **No**

   If no, please identify the emergency equipment that is available in the facility:

   ____

   ____

6. Please identify the percentage of the facility's patients who are pediatric patients: __________ %

   If pediatric patients are treated in the facility, is the facility equipped with age-appropriate emergency equipment and drugs?
   ☐ **Yes** ☐ **No**

   If no, please explain:

   ____

   ____

7. 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:

   ____

   ____

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

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

10. Is all facility equipment (i.e., emergency, etc.) 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 8 – 10, 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?

   ____

   ____

Quality Assurance

1. Does the facility maintain written policies for the handling of emergency situations and are all health care personnel trained on them? ☐ **Yes** ☐ **No**

   If yes:

   a. Are new employees required to complete this training before being allowed patient contact? ☐ **Yes** ☐ **No**

   b. How often is training updated? ____

   If you answered no to question 1 or 1a, please explain:

   ____

   ____

2. Does the facility have a formal process to evaluate and address concerns of unexpected patient outcomes? ☐ **Yes** ☐ **No**

3. Does the facility have a formal process to evaluate patient complaints? ☐ **Yes** ☐ **No**

4. Does the facility conduct patient satisfaction surveys? ☐ **Yes** ☐ **No**

   If yes, how often: ____

Utilization Review

1. Does the facility have its own utilization review committee? ☐ **Yes** ☐ **No**

   If yes:

   a.. Does the facility have written policies and procedures for appeals of denied procedures? ☐ **Yes** ☐ **No**

   b. Who performs the utilization reviews? ____

   ____

   c. Are claim denial procedures explained in writing to patients? ☐ **Yes** ☐ **No**

   d. Does a physician review all proposed denials of benefits? ☐ **Yes** ☐ **No**

   e. Is there a fast track appeal system for denied procedures that may severely impair the quality of life for a patient if not performed? ☐ **Yes** ☐ **No**

Medical 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. Do the facility's health care providers create and maintain a medical record for each patient under their care? ☐ **Yes** ☐ **No**

3. Is it a requirement that procedure/treatment notes be dictated/written on the day of the procedure/visit? ☐ **Yes** ☐ **No**

If you answered no to question 2 or 3, please explain:

____

____

4. 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 14 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:

   ____

   ____

3. Please attach a roster of all individuals who provided services on behalf of the facility since the Requested Retroactive Date, excluding those individuals currently providing services on behalf of the facility. The roster must contain the following items for each individual:

   - Name and designation
   - Type of provider (i.e., physician, nurse practitioner, registered nurse, etc.)
   - Whether the individual was a partner/shareholder, employee, independent contractor or staff member
   - Dates the individual provided services on behalf of the facility

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): __________

CLAIM INFORMATION NARRATIVE

Please describe the care and treatment of the patient. Attach additional pages as needed. Your narrative must provide adequate clinical detail to allow proper evaluation by a committee of physicians and must include the following information:

- Condition and diagnosis at time of treatment
- Dates and a description of treatment rendered
- Condition of patient subsequent to treatment
- Copies of patient(s) chart(s) and operative report(s) as appropriate

I understand the information submitted herein becomes part of my facility's insurance application as submitted.

Signature of Authorized Representative

Date

Name (Print)