



## Non-Direct Healthcare Services Supplemental Application New Business

### Instructions:

- This application must be completed in addition to the Healthcare Facility General Application for Liability Insurance.
- Please print or type clearly all responses and answer all questions as instructed.
- If you need more space for a response, continue in the Comments section of this application or attach a separate sheet of paper.
- Coverage will not be considered until this supplemental application and the general application are completed and all required documents are provided.

**Name of Applicant:** \_\_\_\_\_  
(Whenever used, the term "Applicant" shall mean all entities proposed for coverage.)

Indicate the type of service(s) provided by the Applicant and complete the sections as instructed.

#### TYPE OF SERVICE

- Laboratory
- Pharmacy
- Blood/Plasma Bank
- Organ Bank

#### APPLICATION INSTRUCTIONS

- Complete Sections A and B
- Complete Sections A and C
- Complete Sections A and D
- Complete Sections A and E

### A. General Information

1. Specify where services are provided:

- Free Standing
- Hospital
- Outpatient Facility
- Inpatient Facility
- Long Term Care Facility
- Physician Office
- Other (specify): \_\_\_\_\_

2. Is the Applicant involved in any research activities?  Yes  No  
If yes, please describe the research activity in the Comments section.

3. Include all states in which business is conducted: \_\_\_\_\_

4. Are management services performed for other facilities?  Yes  No  
If yes, please describe the services provided in the Comments section.

### B. Laboratory

1. Does the Applicant provide any of the following services?

- Assisted Reproductive Treatment/Techniques
- Paternity Testing
- Cytology

2. Is sperm or embryo storage provided?  Yes  No

### C. Pharmacy

1. Does the Applicant manufacture any drugs or drug products?  Yes  No  
If yes, please describe in the Comments section.

2. Are any of the following services provided? Please indicate if not applicable.  N/A

- Administration of Medication       Case Management       Compounding  
 Pain Management                       Patient Monitoring

If any of these services are provided, please further describe the service in the Comments section and include the percentage these services represent in comparison to all services provided.

### D. Blood/Plasma Bank

1. Does the Applicant check with the Donor Deferral Register before donor blood is taken and/or transfused?  Yes  No
2. Is a list of deferred donors maintained to prevent the use of collections from them?  Yes  No
3. Is Nucleic Acid Testing (NAT) performed?  
If yes, what percentage of blood is tested by this means? \_\_\_\_\_ %
4. Is leukoreduction performed?  Yes  No
5. Is pathogen inactivation performed?  Yes  No
6. Have FDA recommendations been implemented for the following:
  - a. Preventative measures to reduce the possible risk or transmission of CJD and VCJD?  Yes  No
  - b. Assessment of donor suitability and blood and blood product in cases of possible exposure to anthrax?  Yes  No
  - c. Questions related to potential donors who have recently received the smallpox vaccine?  Yes  No
  - d. Quarantine and disposition of prior collections from donors with repeatedly reactive screening tests for HCV?  Yes  No
7. Is Applicant involved in any operations other than blood banking?  
If yes, describe in the Comments section.  Yes  No
8. Does Applicant contract with another facility to test blood on their behalf?  Yes  No  
If yes, please answer the following questions.
  - a. Is there a contract in place between Applicant and the other facility?  Yes  No
  - b. What professional liability limits does Applicant require the facility to carry? \$ \_\_\_\_\_
  - c. Is a copy of their most recent FDA report kept on file?  Yes  No
  - d. Provide the type of test(s) and total number of tests performed on an annual basis: \_\_\_\_\_

### E. Organ/Sperm/Embryo Bank

1. What is handled, stored or processed by the Applicant?  
 Tissue                       Organ                       Sperm                       Embryo                       Bone Marrow  
 Other (specify): \_\_\_\_\_
2. Indicate which types of services are provided?  
 Recovery                       Processing                       Storage                       Evaluation                       Distribution  
 Determination of Donor Eligibility                       Other (specify): \_\_\_\_\_
3. What is the percentage of donor distribution?

Donor Distribution	Percentage	Donor Distribution	Percentage
For Transplant	%	For Teaching	%
For Research	%	Other (describe):	%

