Supplemental Questionnaire: **Correctional Services**

Instructions:

1. This application must be completed in conjunction with the Pro-Praxis Allied Healthcare Application.
2. Answer ALL questions completely, leaving No blanks. If any questions, or part thereof, do not apply, print "n/a" in the appropriate space. Any spaces left blank will be interpreted to not apply.
3. This application must be completed, dated and signed by a Principal or Officer of your firm. Underwriters will rely on all statements made in this application.

Applicant Name: _____

1. Are you a:
   - ☐ Minimum Security Prison
   - ☐ Maximum Security Prison
   - ☐ County Jail
   - ☐ Detention Centers, incl. Juvenile
   - ☐ Restitution Center
   - ☐ Community Correction Center
   - ☐ Group Homes
   - ☐ Other (specify): _____

2. Provide % of population served?
   Juvenile ___% Adults (M) ___% Adults (F) ___%

3. Type of service provided: (check all that applies and % of operations)
   - ☐ Basic Healthcare ___% (minor medical conditions, health screenings, tests, vaccinations)
   - ☐ Minor Surgical Procedures ___% (wart removal, in grown nail avulsion)
   - ☐ Physical Rehabilitation Treatment ___%
   - ☐ Pediatric Care ___%
   - ☐ Emergency/ Urgent Care ___%
   - ☐ Routine Lab Testing ___%
   - ☐ Diagnostic Imaging ___%
   - ☐ Women's Health ___%
   - ☐ Other (specify): ___%
   - ☐ Behavioral Health ___%

4. List number of inmates (all location combined):

Prior Year	Current	Projected 12 months

5. Do your health services include:
   a. Invasive surgical procedures ☐ Yes ☐ No
      If yes, explain: ___
   b. Onsite Infirmary ☐ Yes ☐ No
      # of beds: ___
      Males and females segregated? ☐ Yes ☐ No
      Provide acute medical and behavioral health care ☐ Yes ☐ No
   c. Treatment for substance abuse withdrawal ☐ Yes ☐ No
   d. Pregnancy care ☐ Yes ☐ No
   e. After hours care ☐ Yes ☐ No
   f. Clinical and/or pharmaceutical research/trials ☐ Yes ☐ No

6. Does the Medical Director have Certified Correctional Health Professional (CCHP) designation? ☐ Yes ☐ No

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7. Is there a formal referral process in place for those inmates who require additional clinical assessment, diagnosis and treatment? ☐ Yes ☐ No

8. Are inmates provided with written discharge instructions including how to follow up for emergency treatment? ☐ Yes ☐ No

9. Do you have formal policies and procedures that include:

Rape Crisis Management	☐ Yes ☐ No
Infection Control	☐ Yes ☐ No
Emergency Management of acute healthcare needs	☐ Yes ☐ No
Procedures in the event of an inmate death	☐ Yes ☐ No
Suicide Prevention	☐ Yes ☐ No
Credentialing/Privileging	☐ Yes ☐ No
Criminal background checks on all employed/contracted staff	☐ Yes ☐ No

This application does not bind YOU or US to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

APPLICANT'S NAME AND TITLE: _____

APPLICANT'S SIGNATURE: _____ DATE: _____
(Must be signed by an active owner, partner or executive officer.)

PRODUCER'S SIGNATURE: _____ DATE: _____