Supplemental Questionnaire: **Laboratory/ Imaging/ Lithotripsy Centers**

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. Is your business involved in: ☐ Lab Services ☐ Imaging Services ☐ Lithotripsy

2. Where do you provide services?
   Free Standing Facility ___% Doctor's Office/Clinic ___% Hospital ___%
   Inpatient Facility ___% Neonatal ___% Nursing Home ___%
   Mobile Unit ___% Other ___%

3. Do you:
   a. Have a formal equipment maintenance program in place? ☐ Yes ☐ No
   b. Train employees to properly operate medical equipment? ☐ Yes ☐ No

4. If Lab: ☐ n/a
   ☐ Pathology ☐ Dental & Ocular ☐ Quality Control ☐ Cardiac Cath.
   Do you:
   a. Maintain CLIA certification? ☐ Yes ☐ No
   b. Participate in clinical research? ☐ Yes ☐ No
   c. Perform drug & alcohol testing? ☐ Yes ☐ No
   d. Oerform DNA/ Forensic analysis? ☐ Yes ☐ No
      If Yes, please explain: _____

5. If Imaging: ☐ n/a
   ☐ CT/PET/MRI Scans ☐ X-Ray Diagnostic ☐ X-Ray Therapeutic
   Are you:
   a. A member of the American College of Radiology ☐ Yes ☐ No
   b. A FDA Certified Mammography facility ☐ Yes ☐ No

6. If Lithotripsy, check all that apply: ☐ n/a
   ☐ Conservative treatments (e.g. dietary modifications, high fluid intake, medications)
   ☐ Extracorporeal Shock Wave Lithotripsy (ESWL) or (SWL) – focused shock wave sources
   ☐ Genito-Urinary Endoscopic Lithotripsy – Unfocused shock wave sources
   ☐ Chemolysis ☐ Laser Lithotripsy ☐ Stent Insertion
   ☐ Stone Retrieval & Manipulation ☐ Nepholithotomy – Open Surgery ☐ Pyelolithotomy - Open Surgery
   ☐ Ureterolithotomy - Open Surgery ☐ Percutaneous Nephrostolithotomy

   a. Do you administer anesthesia (other than topical)? ☐ Yes ☐ No
      *If Yes, please explain: _____

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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: _____ _____