## Supplemental Questionnaire: Pharmacy 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: Retail Wholesale Closed Door 1. Is your business involved in: Compounding Mail Order DME/ Infusion 2. Are you a member of the Institute for Safe Medication Practices (ISMP)? Yes No 3. Prescriptions filled: Last 12 months \_\_\_\_\_ Next 12 months \_\_\_\_\_ Annual gross receipts: 4. in last 12 months for next 12 months **Prescription Sales** \$ \$ Sundries Sales \$ \$ **Medical Equipment Sales** \$ \$ In-home Therapy \$ \$ Marijuana Dispensary \$ \$ Other \$ \$ 5. Are there policies in place for: (check all that applies) Medication dispensing Medication Administration Medication Storage 6. If compounding: n/a a. Are you PCAB accredited?  $\exists$  Yes  $\Box$  No b. Are all drugs FDA approved? Yes  $\square$  No c. Do you compound in bulk? Yes  $\square$  No d. Do you possess a sterile compounding license ? Yes No e. Were you recently investigated by the FDA Yes 🗌 No \*If yes, explain:

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.)

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PRODUCER'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_