Supplemental Questionnaire: **Surgery 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. Provide a list of all owners including their ownership percentage :

Name	Ownership
	__%
	__%
	__%
	__%
	__%

Must total 100%

2. What type of procedures do you perfotr?

Type of Procedure	Projections for Current or Expiring Year	Projections for Requested Coverage Period	Type of Procedure	Projections for Current or Expiring Year	Projections for Requested Coverage Period
Bariatric	_____	_____	Ophthalmology (cataracts)	_____	_____
Cardiac Catheterization	_____	_____	Oral and Maxillofacial	_____	_____
Colon and Rectal	_____	_____	Orthopedic	_____	_____
Cosmetic	_____	_____	Otolaryngology (ENT)	_____	_____
Endoscopy	_____	_____	Pain Management	_____	_____
Gastroenterology	_____	_____	Plastic (reconstructive)	_____	_____
General	_____	_____	Podiatry	_____	_____
Gynecology	_____	_____	Thoracic	_____	_____
Hand	_____	_____	Urology	_____	_____
Head and Neck	_____	_____	Vascular	_____	_____
Neurology	_____	_____	Wound Care	_____	_____
Obstetrics	_____	_____	Other – specify: _____	_____	_____
Ophthalmology (Lasik, PRK, TKP)	_____	_____			

Visit: One visit applies each time a patient enters the facility for healthcare related services regardless of the number of departments visited or the number or procedures/treatments performed within each department. Each threshold crossing for a pre-surgical and post-surgical visit is counted as a separate visit apart from the number of surgeries or procedures.

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3. Do you:
   a. Administer anesthesia (other than topical) ☐ Yes ☐ No
      Who administers anesthesia?
      ☐ Physician ☐ CRNA ☐ Other: specify:_____

   b. Perform plastic surgery? ☐ Yes ☐ No #:_____
      ☐ Abdomen ☐ Eyes ☐ Nose
      ☐ Breast ☐ Face & neck ☐ Pediatric
      ☐ Ears ☐ Extremities ☐ Other: specify:_____

   c. Perform breast implant surgery? ☐ Yes ☐ No #:_____
   d. Perform Liposuction? ☐ Yes ☐ No #:_____
   e. Perform robotic surgery? ☐ Yes ☐ No #:_____
   f. Perform neurosurgery? ☐ Yes ☐ No #:_____
   g. Perform elective cosmetic surgery? ☐ Yes ☐ No #:_____
   h. Perform *medispa type of services? ☐ Yes ☐ No #:_____
      **Please provide list of services & # of procedures in a separate attachment.*

   i. Train employees to properly operate medical equipment? ☐ Yes ☐ No
   j. Have a formal equipment maintenance program in place ? ☐ Yes ☐ No
   k. Have formal emergency transport policy in place? ☐ Yes ☐ No
   l. Operate inpatient beds? ☐ Yes ☐ No
   m. Registered as a surgical hospital? ☐ Yes ☐ No
   n. Have a formal agreement in place with a local hospital? ☐ Yes ☐ No
      *What is the average distance to Level III or higher hospital emergency department? _____

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: _____