Supplemental Questionnaire: **Treatment 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 a:
   - ☐ Cancer Treatment Center
   - ☐ Community Health Center
   - ☐ Convenience Care/ Retail Clinic
   - ☐ Crisis Stabilization Centers
   - ☐ Dialysis Centers
   - ☐ Endoscopy Centers
   - ☐ Fertility Clinics
   - ☐ Optical Facility
   - ☐ Sleep Center
   - ☐ Student Health Center
   - ☐ Substance Abuse/ Detox Center
   - ☐ UrgiCenter
   - ☐ Weight Loss Center
   - ☐ Other (specify): _____

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

   *Average distance to Level III or higher hospital emergency department: _____

3. Type of service provided: (check all that applies and % of operations)
   - ☐ Preventative/ Diagnostic
   - ☐ Pediatric Primary Healthcare
   - ☐ Emergency/ Urgent Care
   - ☐ Invasive/ Minor Surgery
   - ☐ Weight Loss Centers
   - ☐ Lab & Imaging Services
   - ☐ Women's Health Service
   - ☐ Prenatal Care
   - ☐ Birthing & Abortions
   - ☐ Other (specify):

4. Do you:

a.	Administer anesthesia (other than topical)	☐ Yes	☐ No	☐ n/a
b.	Dispense controlled narcotics?	☐ Yes	☐ No	☐ n/a
c.	Dispense weight loss drugs?	☐ Yes	☐ No	☐ n/a
d.	Train employees to properly operate medical equipment?	☐ Yes	☐ No	☐ n/a
e.	Have a formal equipment maintenance program in place ?	☐ Yes	☐ No	☐ n/a
f.	Accept walk-ins?	☐ Yes	☐ No	☐ n/a
g.	Provide after-hours care?	☐ Yes	☐ No	☐ n/a
h.	Have an exercise facility on site?	☐ Yes	☐ No	☐ n/a
	*If yes, is it open to the public?	☐ Yes	☐ No	☐ n/a
i.	Perform any surgical procedures?	☐ Yes	☐ No	☐ n/a

*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: _____

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APPLICANT'S SIGNATURE: _____ DATE: _____

(Must be signed by an active owner, partner or executive officer.)

PRODUCER'S SIGNATURE: _____ DATE: _____