

Christian Brothers

# RISK MANAGEMENT SERVICES

a division of Christian Brothers Services

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## LIMITED PROFESSIONAL HEALTH CARE SERVICES APPLICATION

This application should be completed by any organization requesting Professional Liability coverage through the Christian Brothers Risk Pooling Trust. This application does not apply to hospitals, emergency facilities, outpatient clinics, laboratory facilities, obstetrical delivery services including Midwifery, Doctors, Psychiatrists, Physician Assistants, Osteopaths, Chiropractors, Pharmacists, Dentists, Orthodontists, Endodontists, Periodontists, students, any Review Board/Victim Outreach services or programs as they are excluded from coverage.

Location Name		Location Code	
Location Address			
Telephone No.		Fax No.	
		E-mail	

I. Please indicate the type of professionals needing coverage and the number of professional employees you have in each category. Please distinguish between Lay professionals (“L”) and Religious professionals (“R”).

	<u>“L”</u>	<u>“R”</u>		<u>“L”</u>	<u>“R”</u>
Athletic Trainer	# _____	_____	Paramedic/EMT	# _____	_____
Clinical Nurse Specialist	# _____	_____	Physical Therapist	# _____	_____
Dietician/Nutritionist	# _____	_____	Psychologist	# _____	_____
Licensed Practical Nurse	# _____	_____	Recreational Therapist	# _____	_____
Licensed Vocational	# _____	_____	Registered Nurse	# _____	_____
Massage Therapist	# _____	_____	Social Worker	# _____	_____
Music or Art Therapist	# _____	_____	Speech Pathologist	# _____	_____
Nurse’s Aide/Assistant	# _____	_____	Other	# _____	_____
Nurse Practitioner	# _____	_____			
			Counselor—Do <b><u>NOT</u></b>		
			include Academic or	# _____	_____
			Pastoral	_____	_____

**NOTE:** If any of the above individuals are working at sites other than the above address, please attach a detailed listing of

all employers and addresses to this application.

**II. IF YOUR FACILITY IS A NURSING HOME, RETIREMENT HOME, CONVALESCENT HOME, OR A GROUP HOME, PLEASE COMPLETE THE FOLLOWING:** Are you open to the general public, or does your facility serve religious order members only? \_\_\_\_\_

**A. Facility Classification and Bed Census**

**1. Skilled Care Services**

Professional nursing care – 24 Hours by licensed nurses. RN coverage during the day shift, LPN coverage required during other shifts. Skilled care services usually include injections, catheterizations, tube feedings, IV's, etc.

Total No. of Skilled Care Beds \_\_\_\_\_ Avg. No. Occupied \_\_\_\_\_

**2. Intermediate Care Services**

Intermediate Care Services usually include assistance with activities of daily living (i.e., walking, bathing, dressing, and eating).

Total No. of Intermediate Care Beds \_\_\_\_\_ Avg. No. Occupied \_\_\_\_\_

**3. Residential Care Services**

Residents are provided protective environments (meals and planned programs for social and/or spiritual needs). Residents responsible for their own medication.

Total No. of Residential Care Beds \_\_\_\_\_ Avg. No. Occupied \_\_\_\_\_

**B.** In addition to the above described services, do you also provide separate “independent living” accommodations?  YES  NO If yes, number of units? \_\_\_\_\_

**C.** Describe any recreational building or equipment features at this location (i.e., swimming pool, exercise equipment, etc.) \_\_\_\_\_

**D.** Describe any outpatient services provided by your facility (i.e., home health care, physical therapy, etc.), including the number of such visits per year.

\_\_\_\_\_  \_\_\_\_\_ # Visits

**E.** Do you accept patients who are either chemically dependent, physically impaired, or mentally/emotionally disturbed?  YES  NO

**F.** Do you obtain advance (patient or guardian) written consent that allows your facility to provide non-emergency medical care when it is needed?  YES  NO

**G.** Do you retain an on-site or on-call physician on a 24 hour basis?  YES  NO

**H.** Is smoking permitted in patient rooms?  YES  NO

Describe any other rules applicable to smoking. \_\_\_\_\_  
\_\_\_\_\_

**I.** Describe any professional services provided by a third party under a contractual agreement and submit a copy of each contract. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**III Loss History**

Has a Professional Liability claim or lawsuit been filed against your facility or its employees during the past 5 years?

YES     NO

If yes, please provide the following information:

- a. Name of prior carrier, date of the event, and the date the claim was reported to the insurance company.
- b. Brief description of the cause of the loss or claim.
- c. Current status of the claim (open or closed). The paid amount or current reserve amount.

***Signing this application does not bind Professional Liability coverage. Coverage is bound only upon submission and approval of the Christian Brothers Risk Pooling Trust AND the Professional Liability Carrier(s).***

\_\_\_\_\_  
**Completed by (please print or type)**

\_\_\_\_\_  
**Title**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**