



CHRISTIAN BROTHERS SERVICES

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Romeoville, IL 60446-1679

Risk Management 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, outpatient clinics, laboratory facilities, obstetrical delivery services including Midwifery, Doctors, Pyschiatrists, Physican 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>
<input type="checkbox"/> Athletic Trainer	# _____	_____	<input type="checkbox"/> Paramedic/EMT	# _____	_____
<input type="checkbox"/> Clinical Nurse Specialist	# _____	_____	<input type="checkbox"/> Physical Therapist	# _____	_____
<input type="checkbox"/> Dietician/Nutritionist	# _____	_____	<input type="checkbox"/> Psychologist	# _____	_____
<input type="checkbox"/> Licensed Practical Nurse	# _____	_____	<input type="checkbox"/> Recreational Therapist	# _____	_____
<input type="checkbox"/> Licensed Vocational	# _____	_____	<input type="checkbox"/> Registered Nurse	# _____	_____
<input type="checkbox"/> Massage Therapist	# _____	_____	<input type="checkbox"/> Social Worker	# _____	_____
<input type="checkbox"/> Music or Art Therapist	# _____	_____	<input type="checkbox"/> Speech Pathologist	# _____	_____
<input type="checkbox"/> Nurse’s Aide/Assistant	# _____	_____	<input type="checkbox"/> Other	# _____	_____
<input type="checkbox"/> Nurse Practitioner	# _____	_____	<input type="checkbox"/> Counselor–Do <i>NOT</i> 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?

Is your facility licensed?

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 _____

Total No. of Residential 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.

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