ADMIRAL INSURANCE COMPANY
1255 Caldwell Road
Cherry Hill, NJ 08034
Phone: 856-429-9200- Fax: 856-429-8611
Internet: http://www.admiralins.com

APPLICATION FOR
EMT/PARAMEDIC PROFESSIONAL LIABILITY
INSURANCE
(CLAIMS MADE FORM)

1. **Name of Applicant :**_____

   Address:_____
   Street **City/State** **Zip**

   Applicant's Website Address:_____**Telephone #:(_____)**_____

2. **Applicant is:** **[] Private for-profit ambulance service (not Hospital based)**
   [] Public ambulance service (city or county owned)
   [] Non-profit ambulance service
   [] Hospital owned ambulance service
   [] Fire Department/Rescue Squad
   [] other-describe:_____

3. **Date service was Established _____(mm/dd/yy)**

4. **Has your service had any change in ownership over the last 3 years? Yes [] No [] If yes, please explain.**
   _____
   _____

Operations:

5. **Total Calls and Vehicle Units:**

	This year	Last Year	Next Year
Emergency Calls			
Non-Emergency Calls			
Vehicle Units			

6. **Gross Annual Receipts/Revenue:**
   This Year _____ **$**_____
   Last Year _____ **$**_____
   Next Year _____ **$**_____

7. **Check any of the following which your service performs: (if NONE check here [])**

   [] Mast Trousers **[]EQA** **[]IV therapy/monitoring** **[] Drug therapy** **[] Intubation** **[] Defibrillation**

8. **Do you employ or contract the services of a Medical Director? Yes [] No []**
   If Yes, please provide resume as attachment to this application.

9. **Staff:**

	EMPLOYED	CONTRACTED	VOLUNTEER
Administrator/Director/Supervisor:	_____	_____	_____
EMT (basic):	_____	_____	_____
EMT (advanced)	_____	_____	_____
EMTParamedic	_____	_____	_____
Dispatchers	_____	_____	_____
Administration/clerical	_____	_____	_____
Other-describe_____	_____	_____	_____
Total	_____	_____	_____

10. **Do you require: Pre-employment physical exams [] Periodic physical exams []**

11. **Are all technicians state/nationally certified prior to patient care? Yes [] No []**

12. **Are records maintained as to the certification status of all technicians? Yes [] No []**

13. **Are records monitored to ensure technicians are in compliance with certification requirements? Yes [] No []**
    If Yes, are these records checked: annually [] bi-annually [] monthly []
    Who is responsible for monitoring?_____

14. **Do you employ or contract nurses or physicians for critical care transportation or other medical services? Yes [] No [] <u>If Yes, please explain transports/services and include individual professional application for nurse/physician by separate attachment.</u>**
    If the nurses or physicians are independent contractors what limits of professional liability do you require that they maintain?$_____.
    Do you record certificates for your records? Yes [] No
    Do you verify that all nurses and physicians are currently state licensed? Yes [] No []

15. **Who dispatches you calls? [] 911 [] In-house by your own employees [] Outside service**

    a. <u>If Outside service, please attach copy of your contract with the provider.</u>

    b. If In-house:

    What are the minimal education requirements for hire? [] High School [] some College []College Graduate
    Do you provide in-house training? Yes [] No [] min hours for training_____
    Are dispatchers trained in Pre-arrival instructions or CPR/First Aid? Yes [] No []

    c. Is a standard call report completed for every call? Yes [] No []
    d. Who reviews the standard call reports for completeness, legibility and content?_____
    e. When are these reviews completed? [] daily [] weekly [] monthly
    f. How many shifts do you run?_____ Hours p/shift?_____
    g. When an ambulance is dispatched how many EMT/Paramedics accompany the driver?_____
    h. Are all emergency vehicles equipped with the first aid supplies and medical equipment mandated by state regulations? Yes [] No []
    i. Are you involved in any of the following:
    [] Special Event/Sports EMS
    [] Offshore EMS or Water rescue
    [] Air Ambulance
    [] Activities other than EMS

16. **What is the radius of your operations: [] 0-50 miles [] 50-100 miles [] over 100 miles**

17. **What is the estimated population of the area you service?_____**

18. **How often is a condition and supply report completed on each ambulance? [] Buy run [] By shift [] Daily**

19. **Is there written standard operation manual provided to employees? Yes [] No []**
Does this manual include specifics on medical waste disposal/containment? Yes [] No []

20. **Are MVR's checked for all drivers? Yes [] No [] Are they checked: [] bi-annually [] annually**

21. **Have you maintained continuous coverage for Professional Liability? Yes [] No []**

Please provide Professional Liability policy information for the last 3 years.
(if no current Professional Liability insurance is in place check here NONE [])

Carrier	Limits	Deductible	Retro Date	Premium	Exp. Date

22. **General Liability:** **Carrier:**_____ **Exp. Date:**_____
Limits:_____ **Deductible:**_____
Retro Date:_____

23. **Automobile Liability:** **Carrier:**_____ **Exp. Date:**_____
Limits:_____ **Deductible:**_____

24. **Has any insurer cancelled/refused to renew any insurance coverage during the last 5 years? Yes [] No []**
If Yes, please provide details on separate attachment.

25. **Has any professional liability claim or suit been made against you, any predecessor in business or against any past or present partner/officer(s)? Yes [] No []**
If Yes, please provide on separate attachment these details –allegations, amount of damages/demand, date of loss/date claim made/reserve amounts for indemnity and expenses as well as paid amounts for indemnity and expenses. Attach currrently valued loss runs for 5 years.

Are you aware of any circumstance or incident which may result in any claim against you? Yes [] No []
If Yes, please provide details on separate attachment.

The Applicant declares that the above statements and representations are true and correct and that no facts have been suppressed or misstated. The completion of this application does not bind the Company to sell no the Applicant to purchase this insurance, but any subsequent contract issued will be in full reliance upon the statements and representations made in this application and this application will be made part of the policy.

The Applicant understands that any subsequent contract issued by the Company will be issued on a CLAIMS MADE FORM.

_____ _____

Signature of Applicant **Date**

_____

Title (Officer/Director/Administrator)