Equity Partners Insurance Services, Inc	**Allied Medical - Healthcare Division**	**Medical Imaging Centers Application** **EMAIL:** submissions@epinsurance.com **WEBSITE:** www.epinsurance.com/alliedmedical-healthcare/

APPLICANT'S INSTRUCTIONS:

1. Answer all questions completely. Please attach extra sheets as required. Incomplete or illegible applications may be discarded.
2. Application must be signed and dated by the owner, partner, or officer not earlier than 45 days before the proposed effective date of coverage.
3. Please read the statements at the end of this application carefully. Thank you!

ALLIED HEALTHCARE – MEDICAL IMAGING CENTERS

(SUBMIT WITH ALLIED HEALTHCARE GENERAL APPLICATION)

Applicant Name: _____

1. Service is provided for: Hospitals: _____ % Nursing Homes: _____ %
   Physicians' Offices: _____ % Industrial Facilities: _____ %
   Other: _____ (describe) _____
2. Number of tests performed last 12 months: _____
   Anticipated next 12 months: _____
   Number of patient contacts last 12 months: _____
   Anticipated next 12 months: _____
3. For medical imaging centers, indicate number of tests in each category:
   MRIs: _____ CT Scans: _____ Mammograms: _____
   Diagnostic x-rays: _____ Ultrasounds: _____
   Other (describe): _____
4. Name and qualifications of Medical Director * _____
   Name and qualifications of Medical Review Officer * (MRO) _____
   *** Attach Curriculum Vitae (C.V.)**
5. Specimens: _____ **%** Collected direct from patient by applicant.
   Describe types of specimens collected: _____
   _____
   _____ % Received by applicant from outside sources.
6. Is applicant involved in any? (If Yes, attach full description)
   a. Services open to the public (health fairs, shopping mall exhibits, etc.) Yes ☐ No ☐
   b. Blood banking or cross matching Yes ☐ No ☐
   c. Medical, genetic, AIDA or drug research Yes ☐ No ☐
   d. Manufacturing, dispensing or testing pharmaceuticals Yes ☐ No ☐
   e. Use of injected or ingested materials Yes ☐ No ☐
   f. Use of any radioactive material other than normal x-ray equipment Yes ☐ No ☐
   g. Therapy or treatment procedures Yes ☐ No ☐

h. Environmental analyses Yes ☐ No ☐

i. Manufacturer and/or sell laboratory equipment or supplies, reagents or software Yes ☐ No ☐

j. Intravenous transfusions of blood or in the procurement of blood or blood products Yes ☐ No ☐

k. Illegal drug testing: If Yes, _____ % of your gross receipts Yes ☐ No ☐

l. Testing for AIDS, If Yes, _____% of your gross receipts Yes ☐ No ☐

7. Does applicant provide any services under contract? Yes ☐ No ☐

   If Yes, attach explanation.

8. Is the applicant in the employ of any federal government entity? Yes ☐ No ☐

   If Yes, attach explanation.

9. Does the applicant advertise its professional services in any manner (other than a simple listing in a telephone directory)? Yes ☐ No ☐

   If Yes, attach detailed explanation and a copy of ALL of the advertisements.

10. Is the applicant associated with any agency or organization that engages in any kind of advertising for, or solicitation of, patients? Yes ☐ No ☐

    If Yes, attach detailed explanation and a copy of ALL of the advertisements.

11. Has the applicant or any of its employees ever (If Yes, attach full description):

    a. Been the subject of disciplinary or investigatory proceedings or reprimand by an administrative or governmental agency, hospital or professional association? Yes ☐ No ☐

    b. Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes ☐ No ☐

12. Is the applicant:

    a. Licensed in accordance with all applicable state and federal laws? Yes ☐ No ☐

    b. Approved by National Institute on Drug Abuse (NIDA) if lab is involved in drug testing? Yes ☐ No ☐ N/A ☐

    If No, to either of the above, provide detailed explanation.

13. Has the applicant or any of its employees had any professional license refused, suspended, revoked, renewal refused or accepted only on special terms or has applicant or any of its employees voluntarily surrendered any professional license? Yes ☐ No ☐

    If Yes, provide detailed explanation. _____

14. Is your facility owned by a M.D.? Yes ☐ No ☐

    If Yes, owner name(s): _____

    If Yes, indicate % of total services to the owner's patients: _____ %

15. Describe the referral source(s) by which patients are directed to the entity: _____

    _____

    _____

16. Does your facility participate in any clinical trials or experimental procedures, equipment or product testing? Yes ☐ No ☐

    If Yes, attach a separate sheet describing the facility's involvement and a copy of the protocol, and any contracts involving same.

17. Does your facility own or operate any mobile diagnostic/imaging units? Yes ☐ No ☐

    If Yes, indicate the manufacturer/uses/sites used, and the gross receipts from each unit: _____

18. Is a physician present to administer/supervise the injection of contrast substances? Yes ☐ No ☐

19. Describe the protocol for treating adverse reactions: _____

    _____

20. Are tests/film results interpreted or diagnosed by applicant Yes ☐ No ☐

    Are tests/film results interpreted or diagnosed by third party under contract to applicant to provide said service? Yes ☐ No ☐

    If Yes, in either situation, who diagnoses/interprets? _____

    _____

    _____

21. Describe the patient screening process your facility utilizes for pregnancy, pacemakers, artificial valves, etc.

    _____

22. Does your facility require the professional staff to be CPR trained? Yes ☐ No ☐

23. Who performs the following in your facility?

    a. Calibration of diagnostic equipment? Contractor ☐ Employee ☐

    b. Services/Maintains diagnostics equipment? Contractor ☐ Employee ☐

    If contractors perform either function, attach copy of contract. If employee, advise position and qualifications:

    _____

24. Has there been any equipment failures/problems resulting in injury to a patient? Yes ☐ No ☐

    If Yes, describe event(s) and steps taken to avoid recurrence: _____

25. Do you have policies and procedures in place to report all applicable problems with medical devices to the Federal Drug Administration? Yes ☐ No ☐

26. Are logs kept of all servicing, maintenance, and calibration of precision instruments? Yes ☐ No ☐

27. If performing MRIs, how does the applicant avoid administering gadolinium-based contrast agents to patients that have renal impairment, or to patients who are receiving dialysis treatments?

    _____

28. If performing MRIs, does the applicant's safety protocols include a provision to prohibit patients' oxygen tanks from coming into the MRI suite in order to prevent projectile accidents?

    _____

29. If performing MRIs, how is oxygen administered to a patient should he or she require it during the scan?

_____

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

_____ _____

Applicant's Signature Sub-Producer

_____ _____

Title/Date Producer

APPLICATION MUST BE CURRENTLY SIGNED AND DATED TO BE CONSIDERED FOR QUOTATION.