PROFESSIONAL AND GENERAL LIABILITY APPLICATION
MEDICAL TRANSPORTATION SERVICES

1. Name of Applicant: ____

2. Mailing Address: ____

3. Location Address: ____
(If multiple names and locations, please attach list)

4. Telephone Number: ______________________ Website: ______________________

5. a.) Date Established: ______________ Years under current management: _______________

b.) Entity Type: Corp. ____ Partnership _____ Prof. Assoc. _____ Individual _____ LLC _____

c.) For Profit _______ Non-Profit __________

6. Funding is: Medicare __________% Medicaid __________% Private Pay __________%

7. a.) Desired Effective Date: ____________________

b.) Desired Limits of Liability: $ _______________ / $ _______________

c.) Desired Deductible: $_________________

OPERATIONS

8. Please check all categories that describe services rendered by your organization.

Category	Description
☐ Ambulette or Medical Van Service	Services include transporting clients/patients from residential facilities/homes to physician offices. Drivers are typically non-medical professionals with basic First Aid and/or CPR training.
☐ Non-Emergency Medical Transportation	Services include medical facility-to-facility transports by ambulance. EMT Basic or Intermediate personnel may accompany patients/clients. This category encompasses Basic Life Support (BLS) and Advanced Life Support (ALS) services defined by Medicare.
☐ Emergency Transportation	Services include response to 911 calls or the equivalent. EMT Basic, intermediate and/or Paramedics may accompany patients/clients.
☐ Air Transport	Services include emergency (Medevac) and/or non-emergency transfers by helicopter or fixed-wing aircraft. Physicians, nurses, or EMT's may accompany patients/clients.
☐ Other	Please provide a description of your organization if it does not readily reflect one of the above categories. ____________________ ____________________

9. Specialty Operations / Transports

a.) Check all services that your organization provides:

☐ Air and/or Water Transportation	☐ Dispatch Services
☐ Bariatric Transportation If Yes, what percentage of services _____% Are there a minimum of 2 staff? Yes: ___ No: ___	☐ Mobile Intensive Care / Mobile Neo-Natal Intensive Care
☐ Organ Delivery / Donation Transportation	☐ Sporting Events / Concerts / Fairs / Special Events
☐ International Transportation	☐ School Transportation / Youth Transportation
☐ Involuntary Transportation (psych and/or correctional facility)	☐ Funeral Homes / Mortuary Services
☐ Ridesharing / Taxi Transportation	☐ Other: ____

b.) Do you subcontract your services to others? Yes: __________ No: __________

10. Does the applicant have any ancillary operations not stated above? Yes: __________ No: __________
If yes, please provide details____

11. Is the applicant engaged in, owned by, associated with, or controlled by any other business? Yes: _____ No: ______
If yes, please provide details: ____

12. Explain under what circumstances you will refuse to transport a patient:

____

TRANSPORTS and GROSS REVENUES

13. a.) Please enter the number of annual transports and gross revenues:

Types of Service	**# of Transports**		**Gross Revenue**	
	Last 12 months	Projected next 12 months	Last 12 months	Projected next 12 months
Critical / Specialty Care Ambulance			$	$
Emergency (BLS) Ambulance			$	$
Emergency (ALS) Ambulance			$	$
Non-Emergency (BLS) Ambulance			$	$
Non-Emergency (ALS) Ambulance			$	$
Non-Medical / Paratransit / Wheelchair			$	$
Other (Specify)			$	$
TOTAL			$	$

b.) How are calls dispatched? 911: __________ In-House: __________ Other:________________________________

14. Do you offer any CPR, First Aid, or other medical training / certification? Yes: __________ No: __________

15. Please indicate the number of vehicles for each category below:

a.) Advanced Life Support Ambulance __________

b.) Basic Life Support Ambulance __________

c.) Wheelchair Vans / Ambulette __________

d.) Private Passenger Vehicle __________

e.) Other Vehicles (Please specify) __________

TOTAL __________

16. Radius of Operations: ___________

17. a.) What types of wheelchairs are used to transport passengers?

- ☐ Portable
- ☐ Motorized
- ☐ Youth/Child Stroller
- ☐ Lightweight
- ☐ Heavy Duty Industrial
- ☐ Tri-Wheeler/Scooter
- ☐ Reclining/Tilting

b.) Do you have a mandatory lift assist requirement? Yes: __________ No: __________

c.) Are wheelchair passengers ever transported without the use of a restraint system? Yes: _________ No: __________

18. a.) What types of stretchers do you use in your vans? ______________________________

b.) What type of stretcher vehicle securing system do you provide in your stretcher vans? ________________________

c.) At what frequency are employees trained in the use of wheelchair and stretcher security systems?

- ☐ Time of Hire
- ☐ Semi-Annually
- ☐ Annually
- ☐ Post-Accident
- ☐ Other (describe)

STAFF

19. a.) List the number and type of applicant's staff. (If none, state none.)

	Employees		**Independent Contractors**		**Volunteers**	
	Full-Time	**Part-Time**	**Full-Time**	**Part-Time**	**Full-Time**	**Part-Time**
Driver Only						
Advanced First Aid and/or Red Cross						
CPR Certificate Only						
EMT Basic						
EMT Advanced or Intermediate (IV)						
EMT Paramedic						
Nurse (RN or LPN)						
Physician or Surgeon						
Other, Describe						

b.) Are all the above individuals licensed in accordance with applicable state and federal regulations?

Yes: __________ No: __________ If no, attach an explanation.

20. Do you sell, rent, or otherwise provide any equipment or products to others? Yes: __________ No: __________
If yes, give details including types of products and gross receipts from each: _____________________________________
____
____

21. a.) Do you conduct pre-employment screening and investigation? Yes: __________ No: __________

b.) Do you question prospects about previous claims or suits? Yes: __________ No: __________

c.) Do you prepare job descriptions and instructional manuals for your staff? Yes: _________ No: __________

22. Check all the following that apply if obtained, verified, and kept on file as part of the employee hiring and screening process:

Applications / Resume	__________	Criminal Background Checks	__________
Drug Testing	__________	Licenses Held	__________
Education/Training/Competence	__________	Motor Vehicle Report	__________

23. a.) Are there proficiency requirements for newly hired drivers? Yes: __________ No: __________
If Yes, what are the requirements? ____

b.) Have all drivers gone through formal training in the proper techniques to load, unload and secure during transit patients who are in wheelchairs or stretchers? Yes: __________ No: __________
If No, please provide details: ____

c.) Are there policies / procedures in place if a client is under the influence of alcohol and/or mood-altering drugs, violent/combative, requires emergency care or requires transportation for non-medical reasons?
Yes: __________ No: __________
If Yes, please provide details: ____
____

d.) Are there policies / procedures in place to that no one under the age of 18 years old is transported without their parent or legal guardian? Yes: __________ No: __________
If No, please provide details: ____
____

24. ATTACH DETAILED EXPLANATION FOR ANY ""YES"" ANSWERS:

Has the applicant or have any of the above employees:	YES	NO
a.) Ever been the subject of disciplinary or investigative proceedings or reprimand by a governmental or administrative agency, hospital, or professional association?	________	________
b.) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?	________	________
c.) Ever been treated for alcoholism or drug addiction?	________	________
d.) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same?	________	________

25. Professional Liability coverage for last 5 years for the firm: (if none state none)

Carrier	Limits	Deductible	Premium	Expiration (Mo/Day/Yr)
______________	_________________	____________	______________	_____________________
______________	_________________	____________	______________	_____________________
______________	_________________	____________	______________	_____________________
______________	_________________	____________	______________	_____________________
______________	_________________	____________	______________	_____________________

If expiring insurance is a claims made policy, what is the retroactive date? _________________________________

26. General Liability coverage for last 5 years for the firm: (if none state none)

Carrier	Limits	Deductible	Premium	Expiration (Mo/Day/Yr)
______________	_________________	____________	______________	_____________________
______________	_________________	____________	______________	_____________________
______________	_________________	____________	______________	_____________________
______________	_________________	____________	______________	_____________________
______________	_________________	____________	______________	_____________________

If expiring insurance is a claims made policy, what is the retroactive date? _________________________________

27. Automobile Liability coverage information (if none state none)

Carrier	Limits	Deductible	Premium	Expiration (Mo/Day/Yr)
______________	_______________	____________	______________	____________________

28. Has any insurer cancelled or refused to renew any similar insurance during the past 5 years?
Yes: __________ No: __________
If yes, please give full details.

29. Has any claim ever been made against the firm or any of its employees?
Yes: __________ No: __________
If yes, please complete and attach claims supplement with details.

30. Is the applicant aware of any circumstances which may result in any claim against the proposed insured entity or any individual who would be covered by this policy?

Yes: __________ No: __________ If yes, please give full details.

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Application does not bind the undersigned to complete the insurance, but it is agreed that this Application shall be the basis of the contract should a Policy be issued, and that this Application will be attached and become part of such Policy, if issued. Underwriters hereby are authorized to make any investigation and inquiry in connection with this Application, as they deem necessary.

FOR KENTUCKY RISKS: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

Name of Applicant: ____
Please Print Title

Signature: ____
Name Date

(NOTE: Supplement must be signed by the owner or president or principal)