



PHARMACY SUPPLEMENT (Edition 06.2026)

- TO BE COMPLETED ALONG WITH THE GENERAL ALLIED HEALTH APPLICATION -

1. Applicant Name: _____

Section 1: Percentage of Services Provided

2. Please indicate the percentage of total operations represented by each category (Total must equal 100%):

- | | | |
|--|-------|---|
| a) ☐ Retail Pharmacy | _____ | % |
| b) ☐ Compounding | _____ | % |
| c) ☐ Drug Benefit | _____ | % |
| d) ☐ Mail Order | _____ | % |
| e) ☐ Wholesale Distribution | _____ | % |
| f) ☐ Other (Describe) _____ | _____ | % |

Section 2: Prescription Volume & Annual Gross Receipts

3. Number of Prescriptions filled during the past 12 months: _____

4. Provide annual Gross Receipts for the most recently completed fiscal year:

- | | |
|--------------------------------------|----------|
| a) Prescription Sales | \$ _____ |
| b) Sundries / Over-the-Counter Sales | \$ _____ |
| c) Medical Equipment Sales | \$ _____ |
| d) Medical Equipment Rentals | \$ _____ |
| e) In-Home Therapy Services | \$ _____ |
| f) Other (Describe) _____ | \$ _____ |

Section 3: Drug Dispensing Methods

5. Does the applicant dispense any drugs that are imported from outside the United States? ☐ Yes ☐ No
If Yes, please provide details: _____

6. Does the applicant dispense any drugs that are not approved by the U.S. Food and Drug Administration (FDA)? ☐ Yes ☐ No
If Yes, please provide details: _____

7. Are all prescriptions dispensed pursuant to a valid prescription issued by a healthcare provider licensed and authorized to prescribe in the state where services are provided? ☐ Yes ☐ No
If No, provide details: _____

8. Is the applicant in compliance with all applicable federal, state, and local laws and regulations governing the manufacture, compounding, dispensing, distribution, and sale of prescription drugs? ☐ Yes ☐ No
If No, provide details: _____

9. Does the applicant dispense opioid medications? ☐ Yes ☐ No
If Yes:

	Past 12 Months	Next 12 Months (Estimated)
a) Number of Opioid Prescriptions Dispensed:	_____	_____
b) Gross Receipts from Opioid Prescriptions:	\$ _____	\$ _____



Section 4: Specialized Services

10. Does the applicant engage in any of the following specialized or higher-risk operations?

- | | | |
|--|------------------------------|-----------------------------|
| a) Sterile compounding? | ☐ Yes | ☐ No |
| b) Bulk compounding or drug manufacturing? | ☐ Yes | ☐ No |
| c) Wholesale drug distribution? | ☐ Yes | ☐ No |
| d) Pharmacy Benefit Management (PBM) services? | ☐ Yes | ☐ No |
| e) Veterinary pharmacy services? | ☐ Yes | ☐ No |
| f) Medical marijuana, cannabis-related products, or herbal remedies? | ☐ Yes | ☐ No |

If Yes to any of the above, please provide details: _____

Section 5: Prescription Orders and Medication Controls

- | | | |
|--|------------------------------|-----------------------------|
| 11. Are verbal or telephone prescription orders accepted only by licensed pharmacy personnel and read back for verification prior to processing? | ☐ Yes | ☐ No |
| 12. Are medications with known look-alike or sound-alike names segregated and/or otherwise controlled to reduce dispensing errors? | ☐ Yes | ☐ No |
| 13. Does the applicant perform pediatric dose-range checks when applicable? | ☐ Yes | ☐ No |
| 14. Are all prescriptions dispensed with current written instructions and required patient information? | ☐ Yes | ☐ No |
| 15. Does the applicant accept electronic prescriptions? | ☐ Yes | ☐ No |

If Yes, describe the controls used to verify that prescriptions originate from appropriately licensed and authorized prescribers: _____

16. Describe the procedures used for the disposal of expired, recalled, damaged, or waste pharmaceuticals: _____

Signature and Attestation

Application for Claims-Made Professional Liability Insurance

The undersigned declares that to the best of his/her knowledge the statements herein are true. Signing of this Supplement does not bind the undersigned to complete the insurance, but it is agreed that this Supplement shall be the basis of the contract should a Policy be issued, and that this Supplement 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 Supplement, as they deem necessary.

Name of Applicant: _____
Please Print Title

Signature: _____
Name Date

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