Admiral INSURANCE GROUP
a Berkley Company

EMT/PARAMEDIC PROFESSIONAL LIABILITY APPLICATION

(CLAIMS MADE COVERAGE)

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)			
EMT Paramedic			
Dispatchers			
Administration/Clerical			
Other,please 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
Do you employ or contract nurses or physicians for critical care transportation or other medical services? Yes ○ *No* ○

14. *If Yes,please explain transports/services and include individual professional application for nurse/physician by separate attachment.*
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 your calls? ○ 911 ○ In-house by your own employees ○ Outside Service
   a. *If Outside service, please attach copy of your contract with the provider.*
   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	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)

22. General Liability:

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)

23. Automobile Liability:

Carrier	Limit	Deductible	Premium	Expiration (MM/DD/YYYY)

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 currently 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.

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)