ALLIED MEDICAL - MEDICAL LABORATORIES
SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

I. APPLICANT INFORMATION

1. Applicant Name: ______________________
2. Mailing Address: ______________________
3. City, State, Zip: ______________________
4. County: ______________________ 5. Telephone Number: ______________________
5. a. Is Applicant CLIA approved? ☐ Yes ☐ No
   b. If Yes, what type of certificate? ______________________

II. OPERATIONS

1. Fully describe your operations, including types of specimens handled. Attach copy of brochure if available. Attach separate sheet(s) if additional space is needed.

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2. Indicate:

	Last 12 Months	Projected Next 12 Months
Annual gross receipts last 12 months:		
Total number of patient contacts last 12 months:		
Total number of tests performed last 12 months:		

3. Indicate whether the Applicant provides any of the following services or treatments on the Applicant's premises:

Service/Treatment	Yes/No	Number of Tests Performed	% of Gross Receipts
Diagnostic Services – Please describe:	☐ Yes ☐ No		
Cytology	☐ Yes ☐ No		
Test result consultation for another lab	☐ Yes ☐ No		
AIDS or HIV testing	☐ Yes ☐ No		
Blood Banking or Blood Storage	☐ Yes ☐ No		
Plasmapheresis Procedures	☐ Yes ☐ No		
Drug Testing	☐ Yes ☐ No		
Pathology	☐ Yes ☐ No		
Histology	☐ Yes ☐ No		
Hematology	☐ Yes ☐ No		
Immunology	☐ Yes ☐ No		
Research	☐ Yes ☐ No		
Quality Control	☐ Yes ☐ No		
Manufacturing, dispensing or testing pharmaceuticals	☐ Yes ☐ No		
Therapy or treatment procedures – Please describe:	☐ Yes ☐ No		
Pap Smears	☐ Yes ☐ No		

4. a. Are there any physicians on staff? ☐ Yes ☐ No
   b. If Yes, do the physicians carry separate professional liability insurance? ☐ Yes ☐ No
5. Categorize all employees and indicate current staffing levels:

Staff	Employed		Contracted	
	Full Time	Part Time	Full Time	Part Time
MD/Physicians				
Nurses				
Cytologists				
Phlebotomists				
Pathologists				
Technicians				
Students or Volunteers				
Other (describe):				

6. Does the Applicant use a reference lab? ☐ Yes ☐ No
7. Indicate percentage of services provided for:
   ______ % Hospitals ______ % Physician Offices
   ______ % Nursing Homes ______ % Industrial Facilities
   ______ % Other – Please describe:
8. Indicate percentage of specimens:
   ______ % Collected from patients directly
   ______ % Received from outside sources

* Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

* Not applicable in all states

WARRANTY STATEMENT AND SIGNATURE:

The undersigned authorized officer of the Applicant declares that the statements set forth herein are the result of said officer's inquiry and, as such, are true, accurate and complete. The undersigned authorized officer agrees that if the information supplied on the application changes between the date the application is signed and the effective date of the insurance that is the subject of this application, such officer will immediately notify us of such changes and we may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. Signing this application does not bind the Applicant to purchase, or us to issue, any insurance policy.

Authorized Signature on behalf of Applicant ______________________ Sub-Producer ______________________

Title/Date ______________________ Producer ______________________

SIGNING THIS FORM DOES NOT BIND THE COMPANY TO ISSUE THIS INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.