SAFETY NATIONAL
Casualty Corporation

a DELPHI company

HOSPITAL/HEALTH CARE SUPPLEMENTAL APPLICATION

Applicant's Representative .... ❑ **New application**

Address .... ❑ **Renewal of policy number**

Effective date ....

1. **Name of applicant** (List only qualified self-insureds.) ....

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2. **Complete the following for emergency conveyances operated or occupied by employees**

TYPE OF CONVEYANCE	OPERATED BY EMPLOYEES		NOT OPERATED BY EMPLOYEES	
	NO. OF UNITS	AVG. NO. OF EMPLOYEES OCCUPYING	NO. OF UNITS	AVG. NO. OF EMPLOYEES OCCUPYING
Ambulance				
Fixed wing aircraft*				
Helicopter*				
Other				

**Aircraft Supplemental Application must be completed.*

3. **Is applicant in compliance with all OSHA standards with respect to handling of and contact with ethylene oxide?** ❑ yes ❑ no

If "no," explain. ....

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4. **Does applicant have written procedures regarding the sterilization of instruments?** ❑ yes ❑ no If "no," explain. ....

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5. **Is applicant in compliance with CDC's and OSHA's standards for blood-borne pathogens and infectious disease?** ❑ yes ❑ no

If "no," explain. ....

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6. **Are written and enforced loss control procedures in effect with regard to the following?**

		YES	NO
A.	Communicable disease	❑	❑
B.	Needle sticking and reporting deadlines	❑	❑
C.	Lifting	❑	❑
D.	Handling of body fluids	❑	❑
E.	Radiation exposures	❑	❑

F. Explain any "no" responses ....

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7. **Provide the following patient/resident population information**

PATIENTS/RESIDENTS	PREVIOUS 12 MONTHS	NEXT 12 MONTHS
HIV and AIDS only		
Total (Including HIV and AIDS)		

8 Is applicant involved in any of the following AIDS or HIV related areas?

		YES	NO
A.	Specialization in the treatment of AIDS patients	❑	❑
B.	AIDS research	❑	❑
C.	Clinical testing for the HIV virus	❑	❑

D. Explain any "yes" responses ....

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9 Does applicant provide home health care? ❑ yes ❑ no If "yes," complete the following

DESCRIPTION OF DUTIES	NO. OF EMPLOYEES	AVERAGE PER EMPLOYEE	
		NO. OF VISITS PER MONTH	MILES TRAVELED PER MONTH
RN/LPN			
Nurse's aide			
Housekeeping			
AIDS patient care			
Therapists			
Other			
	Total		

10 Does applicant intend to have this insurance extend to cover non-compensated volunteer employees, if allowed by their state?

❑ yes ❑ no If "yes," complete the following

DESCRIPTION OF DUTIES	NO. OF VOLUNTEERS	TOTAL ANNUAL HOURS WORKED

Volunteers shall be classified and rated in accordance with the appropriate classifications or classifications usual to paid employees engaged in similar occupations. If payroll or remuneration is not determinable, minimum wage may be used.

11 Comments ....

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This is NOT a binder of coverage. The application must be signed by the applicant or the applicant's representative. The applicant represents that all statements made in this application are complete and true and that all material facts have been fully disclosed.

Applicant's Representative .... **Applicant Signature** ....

Date .... **Title** ....