

MEDICAL FACILITIES – KETAMINE SUPPLEMENTAL APPLICATION

THIS SUPPLEMENT IS PART OF THE APPLICATION, INCLUDING A RENEWAL APPLICATION, SUBMITTED BY OR ON BEHALF OF THE APPLICANT FOR THE PROPOSED INSURANCE. THE NOTICES, CONDITIONS, REPRESENTATIONS AND AUTHORIZATIONS CONTAINED IN SUCH APPLICATION ARE INCORPORATED INTO AND APPLY TO THIS SUPPLEMENT.

ACCOUNT INFORMATION

1. Applicant Name (as identified in the Liability Insurance Application for proposed insurance): Doing Business As (DBA): Number of Locations where services are provided:																	
2. Mailing Address:																	
3. Primary Location Address:	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Street:</td> <td colspan="3"></td> </tr> <tr> <td>City:</td> <td style="width: 25%;">State:</td> <td style="width: 25%;">Zip:</td> <td></td> </tr> <tr> <td>County:</td> <td colspan="3">Telephone Number:</td> </tr> <tr> <td colspan="4">Email Address:</td> </tr> </table>	Street:				City:	State:	Zip:		County:	Telephone Number:			Email Address:			
Street:																	
City:	State:	Zip:															
County:	Telephone Number:																
Email Address:																	

OPERATIONS AND ADMINISTRATION

4.	Are any patients under the age of 18? If "Yes," what percentage? _____ If "Yes," are the patient's parents/guardians involved in the patient's care at all times?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Is an informed consent process in place clearly informing patients of all uses and risks? If "Yes," how often is your informed consent process reviewed and updated? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug and Service Administration		
6.	Are all treatments administered by physicians, anesthesiologists, CRNAs or RNs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Are all CRNAs and RNs administering treatment under the supervision of a physician or anesthesiologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Are there processes in place for monitoring patients for signs of abuse/addiction/withdrawal symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.	What percentage of administrations are:	
	a. Intramuscular	_____ %
	b. Subcutaneous	_____ %
	c. Intravenous	_____ %
	d. Intranasal	_____ %
	e. Oral	_____ %
10.	What percentage of services are performed in :	
	a. Hospitals	_____ %
	b. Stand alone clinics	_____ %
	c. Ambulatory Surgery Center	_____ %
	d. Other (describe) _____	_____ %
11.	Are all treatments prescribed by a medical doctor or other professional with prescriptive authority?	<input type="checkbox"/> Yes <input type="checkbox"/> No

12.	Are emergency protocols in place for respiratory depression?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13.	Are reversal agents on hand at all times?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ketamine for Mental Disorders		
14.	Are all diagnoses of mental disorders made by medical professionals trained in the use of Ketamine therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
15.	Prior to prescribing ketamine for depression, have all other pharmacotherapeutic options been exhausted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16.	Is there a licensed clinician on staff to evaluate behavioral risks including suicidal ideation, severe anxiety, and overall mental status prior to discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17.	Are patients monitored for at least two hours prior to discharge?	<input type="checkbox"/> Yes <input type="checkbox"/> No
18.	Are patients screened for prior issues with addiction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ketamine for Anesthesia/Pain Management		
19.	In what percentage of procedures in your practice is ketamine used?	_____ %
20.	What percentage of procedures is ketamine used for post op pain management?	_____ %
Please attach complete details about all programs offered. Provide a copy of your current resume/experience, State License, and State Inspection		

SIGNATURE AND AUTHORIZATION

The undersigned, as authorized agent of all individuals and entities proposed for this insurance, represents that, to the best of his/her knowledge and belief, after reasonable inquiry, the statements in this Supplement are true and complete.

The notices, conditions, representations and authorizations contained in the Application submitted by or on behalf of the Applicant for the proposed insurance, are incorporated into and apply to this Supplement.

Applicant Name	
By (Authorized Signature)	
Name/Title	
Date	