



CONVENIENCE CARE/RETAIL CLINIC RENEWAL APPLICATION

Instructions:

- Please read the instructions carefully. Complete and submit all requested information and/or required attachments. This application and all materials submitted shall be held in confidence.
- All application questions must be fully answered. If a question does not apply, please write "N/A".
- If you need more space, continue on a separate sheet of your letterhead and indicate the question number.

1. **Name of Applicant:** _____

(Provide names of all legal entities past and present that are intended for coverage. This would include any additional entities acquired this past year).

2. Do you want to change your current insurance structure? Yes No
3. Has the applicant had any change to their business operations over the past 12 months? Yes No
 If "Yes" have the exposures and losses been included with this application? Yes No
4. Are there any plans to acquire other facilities within the next 12 months? Yes No
5. Has there been any change in where services are provided? Yes No

If the answer is "yes" to any of the above, provide details on a separate sheet of your letterhead.

6. Location of Clinic (check all that apply):

- Free Standing Pharmacy Grocery Store Shopping Mall
- Other (Describe): _____

7. Current Number of Patients: _____

- a. Typical % of pediatric patients _____%
- b. Typical % of adult patients _____%

8. Indicate % of Gross Receipts by Type of Care and Visits. "Visits" are defined as the number of patients entering the facility for health related services per year.

Services Provided	% of Gross Receipts	Projected Annual Number of Visits/Revenue as noted
Adult Physical Exams	%	#
Pre-employment physical exams	%	#
Pediatric Exams	%	#
Flu Shots	%	#
Immunizations, including tetanus diphtheria and influenza	%	#
Diabetes/Glucose	%	#
Cholesterol	%	#
Eye Care	%	#
Pregnancy Tests	%	#
TB Testing	%	#
Other (_____)	%	#
Other (_____)	%	#



9. Does the clinic:
- a Have a referral network for patients who are in need of further treatment yes no
 If yes, is the referral network: Urgent Care Center
 Primary Care Physician
 Emergency Department
 - b Provide follow-up patient status calls to all patients? yes no
 - c Provide a follow-up phone number to the patients in the event of a reaction to the vaccination? yes no
 - d Provide instructions for after hour care? yes no
 - e Dispense controlled narcotics? yes no
 - f Provide laboratory services? yes no
 If yes, explain type of services: _____
 - g Employ electronic health records? yes no
 - h Is it a requirement each patient sign an informed consent form? yes no
 If yes, and the applicant serves a bilingual population does the clinic require an English speaking party to witness the informed consent?

10. Provide an updated loss history dated within 60 days for the past 5 years (including the current year) on a report-year basis. Loss data must include the incident/occurrence date, report date/claim made date, expense payments, indemnity payments, expense reserves, indemnity reserves, description of allegation and close date.

AUTHORIZATION

Signature in full

Date

Name - please print

Agency Name and Address	Person submitting application	Telephone Number	E-Mail

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