



HEALTH CARE ACADEMIC PROGRAMS FACULTY/STUDENTS SUPPLEMENTAL APPLICATION

This application must be completed in conjunction with
the CNA Allied Health Care Facilities Common Application.

Instructions:

1. 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.
2. All application questions must be fully answered. If a question does not apply, please write "N/A".
3. If you need more space, continue on a separate sheet of your letterhead and indicate the question number.

1. **Name of Applicant:** _____

2. **Student and Facility**

Indicate the annual number in each applicable category.

COURSE/PROGRAM	TOTAL # OF STUDENTS ENROLLED	% OF STUDENTS IN SENIOR YEAR	TOTAL # FACULTY	TOTAL CLINICAL HOURS FOR FACULTY
Dental				
Emergency Medical Technician/Paramedic				
Nursing – LPN/LVN				
Nursing – Nurse’s Aid				
Nursing – Registered Nurse				
Optometry				
Other - Describe				

Does the program include interns, externs and/or residents? yes no

If “yes” please complete the following:

COURSE/PROGRAM	TOTAL # OF INTERNS	TOTAL # OF EXTERNS	TOTAL # OF RESIDENTS

3. a. **Do faculty members supervise students during clinical training?** yes no
 - b. If “yes”, is there any written agreement with the school and faculty? yes no

4. a. **Do non-faculty members supervise students during clinical training?** yes no
 - b. If “yes”, is there any written agreement with the school and faculty? yes no
 - c. If “yes”, what is the minimum professional liability insurance limits carried?

\$ _____ Each Claim \$ _____ Aggregate



5. a. The clinical portion of the training takes place at a facility that is:

- Non-school Owned School-owned Both

b. If the facility is non-school owned:

- 1) Is there a contractual agreement that requires the school to hold the non-school owned facility harmless for acts of the students while they are at the facility? yes no
- 2) Indicate the minimum professional liability insurance limits required by the non-school owned facility:
\$ _____ Each Claim \$ _____ Aggregate

c. If the facility is school owned:

- 1) Provide the name, if different from the school's and a description of the services provided at the facility:

- 2) Number of outpatient visits (or other exposure): _____

6. Do you require the students to carry their own professional liability insurance?

yes no

- a. If "yes" specify the minimum limits required: \$ _____ Each Claim \$ _____ Aggregate

- b. Is proof of this coverage required? yes no

7. Do you require the faculty to carry their own professional liability insurance?

yes no

- a. If "yes" specify the minimum limits required: \$ _____ Each Claim \$ _____ Aggregate

- b. Is proof of this coverage required? yes no

AUTHORIZATION

Signature in full

Date

Name - please print

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

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