



## SLEEP LABORATORY 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. Is the applicant Accredited?  Yes  No  
 If Yes, by whom? \_\_\_\_\_
7. Location of Clinic (check all that apply):  
 Free Standing     Hospital     University     Other (Describe): \_\_\_\_\_
8. Do all professionals have a valid CPR certification?  Yes  No
9. What is the technician to patient ratio? \_\_\_\_\_
10. Is at least one technician certified by the Board of Registered Polysomnographic Technologists?  Yes  No
11. Is more than one healthcare provider on staff at all times?  Yes  No
12. Is there a mechanism to visually monitor and record patients during testing?  Yes  No
13. Does the applicant have written policies and procedures for:  
 Emergency plan     Each technical procedure  
 Written plan for periodic monitoring of patient related equipment     Quality assurance
14. Written protocols for:  The titration of CPAP     Use of bi-level positive airway pressure
15. Does the staff participate in an average of 10 hours per year in CME over a three year period?  Yes  No
16. Does the applicant sell durable medical equipment?  Yes  No  
 If yes, describe equipment and receipts:

Type of Equipment	Receipts

17. Are all patients referred by a physician?  Yes  No
18. Projected number of annual visits this year: \_\_\_\_\_ Total number of beds at facility: \_\_\_\_\_
19. 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**

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**Signature in full**

**Date**

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**Name - please print**

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

**This product will be underwritten in one of the CNA property/casualty companies. CNA is a registered service mark and trade name of CNA Financial Corporation**