



CONVENIENCE CARE/RETAIL CLINIC 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.

Name of Applicant: _____

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

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

2. Current Number of Patients: _____

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

3. 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 (_____)	%	#



4. 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? yes no

AUTHORIZATION

Signature in full

Date

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