



**Florida Doctors Insurance Company
Healthcare Facility Professional Liability
Imaging Center Supplement**

The supplement is not a complete application for insurance. It must be submitted in conjunction with Florida Doctors Insurance Company's Healthcare Facility Professional Liability Insurance Application and all other required information.

Facility Name: _____

The data provided should be projected for the 12 months to be covered under the policy.

Type of Service Provided	Annual Gross Receipts
Angiography	
Bone Densitometry	
Computerized Tomography (CT)	
EKG / EEG	
ESI, Electron Microscopic Imaging	
Fluoroscopy	
Gamma Camera	
Mammography	
Magnetic Resonance Imaging (MRI)	
Interventional Radiology	
Nuclear Medicine	
Particle Accelerators	
Position Emission Tomography (PET)	
Radiation Therapy	
Ultrasound, Sonography	
Stress Tests, Nuclear Cardiac	
Terahertz Radiation	
Therapeutic Radiology, Cobalt	
X-ray, General Radiography	
Other (describe):	

Do you provide: Initial Read Over-read/second reads External Peer Review Services

Do you transport any radiology equipment? Yes No

 If yes, what percentage of your overall services does mobile technology represent? _____%

Have you implemented a digital PAC radiology system? Yes No

 If yes: When was the system implemented? _____

Do you provide teleradiology services?	Yes	No
If yes: Is the reading physician licensed in all states in the service area?	Yes	No
Does the reading physician reside outside of the U.S. and its territories?	Yes	No
What percentage of your overall services does teleradiology represent?	_____ %	
Are you injecting contrast media?	Yes	No
If yes: What is the percentage of use of:	Ionic _____ %	
	Non-Ionic _____ %	
	Los osmolar _____ %	
Are there protocols for the use of contrast media?	Yes	No
Is a physician present during the injection procedure?	Yes	No
Are you performing mammography?	Yes	No
If yes: Are you FDA certified?	Yes	No
Do you use digital mammography technology?	Yes	No
Have you received any FDA warning letters?	Yes	No
Are all technologists graduates of formal education programs or appropriately certified?	Yes	No
Are all technologists licensed / registered with the state?	Yes	No
Do technologists performing mammography meet the educational & training requirements of MQSA regulations?	Yes	No

SUPPLEMENTAL WAIVER AND RELEASE

As authorized representative for the facility, I hereby acknowledge that the foregoing information constitutes a part of my application for insurance with Florida Doctors Insurance Company (FLDIC). If accepted, I understand that insurance is being issued upon reliance of the truth of my representations. If it is determined that I failed or refused to disclose any relevant fact or information or misled, defrauded or lied to FLDIC, I understand that the policy shall be null and void. However, unintentional errors or omissions do not affect my rights under the policy, if issued. I understand that no insurance will be afforded unless and until this application is accepted by FLDIC and the facility is notified of said acceptance.

Signature of Authorized Representative

Date

Printed Name of Authorized Representative

Title of Authorized Representative

This application form duly completed together with any supplementary information must be signed in ink by an authorized representative of the applicant. A signature on the form does not bind the applicant or FLDIC to complete the insurance.

(A photostat copy of this authorization shall be considered as effective and as valid as the original.)

FLORIDA DOCTORS INSURANCE COMPANY
7751 Belfort Parkway, Suite 100
Jacksonville, Florida 32256
Phone: 800-FLA-DOCS (352-3627) FAX: 904-296-8919
www.FLDIC.com