

INSTRUCTIONS

Complete all sections in full and attach to the main Allied Healthcare & Medical Malpractice application. Incomplete submissions may delay quoting or result in exclusions. Attach additional sheets where required. Use this form where personal support, home care, or residential care services are provided.

SECTION A — APPLICANT & ORGANISATION DETAILS

LEGAL NAME OF ORGANISATION		OPERATING / TRADE NAME (IF DIFFERENT)	
<input type="text"/>		<input type="text"/>	
HEAD OFFICE ADDRESS	CITY	PROVINCE / STATE	POSTAL / ZIP
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PRIMARY CONTACT NAME	TITLE / ROLE	PHONE	EMAIL
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
YEAR ESTABLISHED	# OF CARE LOCATIONS	# OF PROVINCES / STATES	WEBSITE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

TYPE OF CARE ORGANISATION (CHECK ALL THAT APPLY)

- | | |
|---|--|
| <input type="checkbox"/> Home care / in-home support | <input type="checkbox"/> Residential care home |
| <input type="checkbox"/> Long-term care (LTC) facility | <input type="checkbox"/> Assisted living |
| <input type="checkbox"/> Palliative / end-of-life care | <input type="checkbox"/> Adult day programme |
| <input type="checkbox"/> Acquired brain injury (ABI) care | <input type="checkbox"/> Respite care |
| <input type="checkbox"/> Other (describe below) | |

IF 'OTHER', DESCRIBE TYPE OF CARE PROVIDED

SECTION B — SERVICES & CLIENT POPULATION

SERVICES PROVIDED (CHECK ALL THAT APPLY)

- | | |
|--|--|
| <input type="checkbox"/> Personal hygiene / bathing | <input type="checkbox"/> Meal preparation / feeding |
| <input type="checkbox"/> Medication administration | <input type="checkbox"/> Wound care / dressing changes |
| <input type="checkbox"/> Catheter care | <input type="checkbox"/> Continence care |
| <input type="checkbox"/> Mobility assistance / transfers | <input type="checkbox"/> Dementia / cognitive care |
| <input type="checkbox"/> Palliative / comfort care | <input type="checkbox"/> Behavioural support |
| <input type="checkbox"/> Companionship / social support | <input type="checkbox"/> Other (describe below) |

IF 'OTHER', DESCRIBE ADDITIONAL SERVICES

SECTION B — SERVICES & CLIENT POPULATION (continued)

CLIENT POPULATION

TOTAL CLIENTS / RESIDENTS CURRENTLY SERVED	AVERAGE CLIENT AGE	MAXIMUM CAPACITY (IF RESIDENTIAL)
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CLIENT POPULATION TYPES (CHECK ALL THAT APPLY)

- | | |
|--|---|
| <input type="checkbox"/> Elderly / frail | <input type="checkbox"/> Physically disabled |
| <input type="checkbox"/> Cognitively impaired / dementia | <input type="checkbox"/> Acquired brain injury |
| <input type="checkbox"/> Palliative / terminal | <input type="checkbox"/> Mental health (stable) |

CONFIRM NO — tick to confirm both statements apply

- The organisation does NOT provide care to individuals currently detained under the Mental Health Act.
- The organisation does NOT manage or operate any high-security units.

Confirmed — neither of the above applies to this organisation.

SECTION C — STAFFING & PERSONNEL

TOTAL EMPLOYEES (FT + PT)	FULL-TIME STAFF (#)	PART-TIME STAFF (#)	CONTRACTED / AGENCY STAFF (#)
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STAFF BREAKDOWN BY ROLE

ROLE / DESIGNATION	# EMPLOYED	# CONTRACTED	OWN COVERAGE?	
Registered Nurse (RN)			<input type="checkbox"/> Y	<input type="checkbox"/> N
Registered Practical Nurse / LPN			<input type="checkbox"/> Y	<input type="checkbox"/> N
Personal Support Worker (PSW)			<input type="checkbox"/> Y	<input type="checkbox"/> N
Home support worker / care aide			<input type="checkbox"/> Y	<input type="checkbox"/> N
Social worker			<input type="checkbox"/> Y	<input type="checkbox"/> N
Occupational therapist			<input type="checkbox"/> Y	<input type="checkbox"/> N
Physiotherapist			<input type="checkbox"/> Y	<input type="checkbox"/> N
Dietary staff			<input type="checkbox"/> Y	<input type="checkbox"/> N
Administrative staff			<input type="checkbox"/> Y	<input type="checkbox"/> N
Other (specify in notes)			<input type="checkbox"/> Y	<input type="checkbox"/> N

SECTION C — STAFFING (continued)
PRESCRIBING NURSES

Do any employed nurses have prescribing duties?

 Yes No

PRESCRIBING

DRUG CATEGORIES / TYPES PRESCRIBED

RISK MANAGEMENT PROCEDURE

COMPLEMENTARY THERAPISTS

Are any complementary therapists on-site (e.g. hairdressers, chiropodists, massage therapists)?

 Yes No

Are all complementary therapists covered under their own individual professional liability insurance?

 Yes No N/A

IF NOT COVERED INDIVIDUALLY — LIST ROLES AND NUMBER OF THERAPISTS

ON-SITE

HOME / FACILITY MANAGER QUALIFICATIONS

DESCRIBE THE PROCESS FOR VERIFYING MANAGER EXPERIENCE AND QUALIFICATIONS, INCLUDING ANY PREREQUISITES FOR MANAGEMENT ROLES

STAFF SHORTAGES

DESCRIBE HOW STAFF SHORTAGES ARE MANAGED TO ENSURE SUFFICIENT STAFFING LEVELS RELATIVE TO CLIENT NUMBERS AND CARE NEEDS

SECTION D — VETTING & PRE-EMPLOYMENT CHECKS
CONFIRM ALL — tick to confirm YES to each statement. Indicate any NO answers in the field provided.

- Police / criminal record checks are carried out on all staff prior to commencement of employment.
- Reference checks are obtained and verified for all new employees prior to employment.
- Qualifications and credentials are verified for all clinical and regulated staff upon hire.
- Vulnerable sector screening is completed for all staff who work directly with clients.
- Results of all pre-employment checks are retained on file and available for review.
- Agency and contracted staff are subject to the same vetting standards as direct employees.

 Confirmed — all statements above apply to this organisation.

IF ANY STATEMENT ABOVE DOES NOT APPLY — EXPLAIN HERE

SECTION E — TRAINING & COMPETENCY

Confirm that comprehensive training is provided and records of completion and refresher attendance are retained and signed in all employee files.

CONFIRM ALL — tick to confirm YES to each statement. Indicate any NO answers in the field provided.

- All non-medically qualified staff are fully trained and have been declared competent by a qualified doctor or nurse following a period of supervised practice.
 - All staff working towards qualifications are supervised until full competency is confirmed.
 - Comprehensive training is provided in: lifting & handling, dementia care, challenging behaviour, health & safety, needlestick injury protocol, infection prevention & control, and medication administration.
 - All staff are experienced and trained in recognising and managing potentially challenging behaviours.
 - Only well-trained / experienced nurses and senior nursing staff undertake high-risk nursing procedures (e.g. nasogastric feeding, catheter care, wound care, IV administration).
 - Regular refresher training is conducted on all mandatory topics.
 - Proof of training attendance is signed and retained in each employee's personnel file.
 - All staff are trained in recognising characteristics of depression and suicidal tendencies in the client population.
- Confirmed — all statements above apply to this organisation.

IF ANY STATEMENT ABOVE DOES NOT APPLY — EXPLAIN HERE

SECTION F — CLINICAL PROCEDURES & CARE PLANS
NURSING & CLINICAL PROCEDURES

- | | | |
|---|------------------------------|-----------------------------|
| Are nursing procedures (e.g. catheter care, nasogastric feeding, IV therapy) performed on-site? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are all clinical procedures performed exclusively by qualified nurses or regulated health professionals? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are written care plans in place for each client / resident? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are all care plans written and approved by a general practitioner (GP) with their own malpractice coverage? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are care plans reviewed and updated at regular intervals or following any change in client condition? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are medication administration records (MARs) maintained for all clients receiving medications? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is a physician or medical director on call or available for clinical consultation at all times? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

DESCRIBE CLINICAL PROCEDURES PERFORMED ON-SITE

SECTION G — INFECTION CONTROL & HEALTH & SAFETY

CONFIRM ALL — tick to confirm YES to each statement. Indicate any NO answers in the field provided.

- The organisation follows Canadian government guidance on infection prevention and control (IPAC) at all times.
 - Robust health & safety protocols are in place and reviewed at regular intervals.
 - A written infection control policy is maintained and communicated to all staff.
 - PPE (personal protective equipment) is available to all staff and used appropriately.
 - A needlestick / sharps injury protocol is in place and all staff are trained on it.
 - Needlestick and exposure incidents are documented, reported, and followed up appropriately.
 - Hand hygiene protocols are enforced throughout all care settings.
 - An occupational health & safety (OHS) programme is in place in compliance with applicable legislation.
- Confirmed — all statements above apply to this organisation.

IF ANY STATEMENT ABOVE DOES NOT APPLY — EXPLAIN HERE

SECTION H — REGULATORY & QUALITY MANAGEMENT**REGULATORY INSPECTIONS**

Is the organisation subject to inspection by a provincial / state care quality authority?

Yes No

Did any inspection result in findings, improvement notices, orders, or required corrective action?

Yes No

IF YES — DESCRIBE FINDINGS, RECOMMENDATIONS, AND RISK MANAGEMENT ACTIONS IMPLEMENTED

ACQUISITION OF EXISTING CARE PROVIDERS

Has the organisation taken over any existing care providers as a result of poor management or regulatory concerns?

Yes No

IF YES — DESCRIBE THE CIRCUMSTANCES OF THE TAKEOVER AND STEPS TAKEN TO IMPROVE QUALITY OF CARE

SECTION I — CLAIMS HISTORY

Has the organisation, any facility, or any individual staff member ever been subject to a claim, complaint, suit, or demand for compensation arising from care services?

Yes No

If YES — complete the table below for each matter. Attach additional sheets if required.

DATE	NATURE OF CLAIM / ALLEGATION	STAFF / FACILITY INVOLVED	STATUS	PAID (\$)	RESERVED (\$)

Are there any known circumstances that may give rise to a future claim or complaint?

Yes No

IF YES — DESCRIBE IN FULL DETAIL

SECTION J — DECLARATIONS & AUTHORIZED SIGNATURE
IMPORTANT NOTICE

The information provided in this supplementary application forms part of any policy issued and must be read together with the main Allied Healthcare & Medical Malpractice application. The applicant warrants that all statements are true, accurate, and complete to the best of their knowledge. Material misrepresentation or omission may render any policy issued voidable at the option of the insurer.

AUTHORIZED SIGNATORY — NAME (PRINT)

TITLE / POSITION

DATE (MM / DD / YYYY)

SIGNATURE OF AUTHORIZED REPRESENTATIVE