CHUTTER
UNDERWRITING SERVICES

# Pharmacy
## Supplementary Application — Allied Healthcare

**INSTRUCTIONS**
Complete all sections in full. Attach to the main Allied Healthcare & Medical Malpractice application.
Incomplete supplementary applications may delay quoting or result in exclusions.

## SECTION A — PHARMACY DETAILS

LEGAL NAME OF PHARMACY | PHARMACY LICENCE NUMBER | LICENCE ISSUING PROVINCE / STATE

PHARMACY ADDRESS (IF DIFFERENT FROM MAIN APPLICATION) | CITY | PROVINCE / STATE | POSTAL / ZIP

DESIGNATED MANAGER / HEAD PHARMACIST | PHONE | EMAIL

PHARMACY STRUCTURE

- ☐ Standalone / independent pharmacy
- ☐ Pharmacy within a medical / allied health clinic
- ☐ Pharmacy within a hospital or LTC facility

BANNER / FRANCHISE AFFILIATION (E.G. SHOPPERS, REXALL) | # OF LOCATIONS | YEAR ESTABLISHED

HOURS OF OPERATION

Does the pharmacy operate 24-hour dispensing? ☐ Yes ☐ No

## SECTION B — PHARMACY PERSONNEL

LICENSED PHARMACISTS TOTAL (#) | FULL-TIME (#) | PART-TIME (#) | TECHNICIANS / ASSISTANTS (#)

Do all pharmacists hold a current licence in good standing with the applicable College of Pharmacists? ☐ Yes ☐ No

Are all pharmacists required to carry their own individual professional liability insurance? ☐ Yes ☐ No

MINIMUM INDIVIDUAL COVERAGE LIMIT REQUIRED PER PHARMACIST ($) | ARE CERTIFICATES OF INSURANCE COLLECTED AND RETAINED ON FILE?

### ALLIED HEALTHCARE STAFF ON-SITE

If allied health practitioners operate from the same premises, list below. These should also be declared on the main application.

| DESIGNATION / ROLE | # | EMPLOYED OR CONTRACTED? | CARRIES OWN COVERAGE? |
|---|---|---|---|
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## SECTION C — DISPENSING PROFILE

### PRESCRIPTION VOLUMES

ANNUAL PRESCRIPTION VOLUME (#)

AVERAGE DAILY PRESCRIPTIONS (#)

% NARCOTICS / CONTROLLED SUBSTANCES

### OPIOIDS & CONTROLLED SUBSTANCES

Does the pharmacy dispense opioids? ☐ Yes ☐ No

Does the pharmacy participate in a methadone or Suboxone (buprenorphine / naloxone) maintenance treatment program? ☐ Yes ☐ No

METHADONE / SUBOXONE PATIENTS (#)

IS WITNESSED INGESTION REQUIRED FOR ALL PATIENTS?

Are benzodiazepines dispensed? ☐ Yes ☐ No

Are stimulants / ADHD medications (e.g. Adderall, Ritalin) dispensed? ☐ Yes ☐ No

% OF REVENUE — CONTROLLED SUBSTANCES

DESCRIBE CONTROLS / SAFEGUARDS IN PLACE

### CANNABIS

Does the pharmacy dispense medical cannabis / cannabis-based products? ☐ Yes ☐ No

Does the pharmacy sell recreational cannabis? ☐ Yes ☐ No

IF YES — DESCRIBE CANNABIS PRODUCTS DISPENSED / SOLD

% OF REVENUE FROM CANNABIS

## SECTION D — COMPOUNDING SERVICES

| | | |
|---|---|---|
| Does the pharmacy perform any compounding? | ☐ Yes | ☐ No |
| Non-sterile compounding (e.g. topical creams, oral solutions, capsules) | ☐ Yes | ☐ No |
| Sterile compounding (e.g. injectables, IV preparations, eye drops) | ☐ Yes | ☐ No |
| Veterinary compounding | ☐ Yes | ☐ No |
| Hormone replacement therapy (HRT) compounding | ☐ Yes | ☐ No |
| Oncology / chemotherapy compounding | ☐ Yes | ☐ No |

% REVENUE — NON-STERILE COMPOUNDING

% REVENUE — STERILE COMPOUNDING

% REVENUE — ALL COMPOUNDING COMBINED

Does the pharmacy compound for other pharmacies, clinics, or healthcare facilities (i.e. third-party compounding)? ☐ Yes ☐ No

IF YES — DESCRIBE THIRD-PARTY COMPOUNDING ARRANGEMENTS AND VOLUME

Is the compounding area accredited or inspected by the applicable College of Pharmacists or accreditation body?
☐ Yes ☐ No ☐ Pending

LAST INSPECTION DATE

OUTCOME / FINDINGS

## SECTION E — PRODUCTS & RETAIL SALES

PRODUCTS SOLD AT THE PHARMACY (CHECK ALL THAT APPLY)

- ☐ Prescription medications
- ☐ Vitamins / supplements
- ☐ Mobility / assistive devices
- ☐ Skincare / cosmetics
- ☐ Food / grocery items
- ☐ Veterinary products
- ☐ OTC medications
- ☐ Medical supplies / devices
- ☐ Compression garments / orthotics
- ☐ Tobacco / nicotine products
- ☐ Specialty / biologics
- ☐ Other (describe below)

IF 'OTHER', DESCRIBE ADDITIONAL PRODUCTS SOLD

% REVENUE — RETAIL / NON-PRESCRIPTION

## SECTION E — PRODUCTS & RETAIL (continued)

Does the pharmacy operate a compliance packaging / blister pack program (e.g. for LTC, home care, or group home patients)? ☐ Yes ☐ No

APPROX. # OF BLISTER PACK PATIENTS

DESCRIBE PATIENT POPULATION SERVED (LTC, HOME CARE, GROUP HOMES)

Does the pharmacy offer medication delivery (home / mail)? ☐ Yes ☐ No

Are controlled substances included in any delivery program? ☐ Yes ☐ No ☐ N/A

## SECTION F — PATIENT POPULATION & GEOGRAPHY

GEOGRAPHIC PATIENT BASE

☐ Canadian patients only
☐ US patients only
☐ Canadian & US patients
☐ International patients (describe below)

IF INTERNATIONAL, SPECIFY COUNTRIES / REGIONS

% US-BASED PATIENTS

% NON-US INTERNATIONAL PATIENTS

ESTIMATED TOTAL ACTIVE PATIENT COUNT

% PATIENTS WHO ARE MINORS (UNDER 18)

% PATIENTS WHO ARE ELDERLY (65+)

## SECTION G — TECHNOLOGY & ERROR PREVENTION

Is a pharmacy management / dispensing software system in use? ☐ Yes ☐ No

Is a robotic dispensing or automated counting system in use? ☐ Yes ☐ No

Is a pharmacist verification / double-check protocol required for all prescriptions prior to dispensing? ☐ Yes ☐ No

Are pharmacy technicians supervised by a licensed pharmacist at all times during dispensing? ☐ Yes ☐ No

Is a Drug Utilization Review (DUR) / clinical decision support system in use? ☐ Yes ☐ No

Does the pharmacy use electronic prescriptions (e-prescribing) for the majority of prescriptions? ☐ Yes ☐ No

Is patient counselling offered and documented for all new prescriptions? ☐ Yes ☐ No

IF 'NO' TO ANY OF THE ABOVE, PLEASE DESCRIBE

## SECTION H — REGULATORY HISTORY & CLAIMS

### COLLEGE OF PHARMACISTS INSPECTIONS

Has the pharmacy been inspected by the College of Pharmacists in the past 3 years? ☐ Yes ☐ No

Did any inspection result in findings, undertakings, conditions, or required remedial action? ☐ Yes ☐ No ☐ N/A

IF YES — DESCRIBE FINDINGS AND ANY REMEDIAL ACTIONS TAKEN

### DISPENSING ERRORS & ADVERSE EVENTS

Has the pharmacy ever experienced a dispensing error that resulted in patient harm, hospitalization, or death? ☐ Yes ☐ No

Has any pharmacist or pharmacy technician ever been subject to a complaint, investigation, or disciplinary action by a regulatory body? ☐ Yes ☐ No

Has the pharmacy, any entity, or any individual ever been subject to a claim, suit, or demand for compensation related to pharmacy services? ☐ Yes ☐ No

| DATE | NATURE OF MATTER / ALLEGATION | INDIVIDUAL INVOLVED | STATUS | PAID ($) | RESERVED ($) |
|---|---|---|---|---|---|
| | | | | | |
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## SECTION I — 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 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.

FULL NAME (PRINT)

TITLE / POSITION

DATE (MM / DD / YYYY)

SIGNATURE OF AUTHORIZED REPRESENTATIVE