



**SUPPLEMENT FOR AIRAMBULANCE OPERATORS FOR  
SPECIFIED MEDICAL PROFESSIONS PROFESSIONAL LIABILITY INSURANCE**

1. Full legal name and address of Applicant: \_\_\_\_\_  
\_\_\_\_\_
2. (a) Total number of transfers for the last 12 months: \_\_\_\_\_  
(b) Total number of transfers for the next 12 months: \_\_\_\_\_  
(c) Number of emergency transfers for the past 12 months: \_\_\_\_\_  
(d) Numbers of emergency transfers for the next 12 months: \_\_\_\_\_
3. Radius of operation: \_\_\_\_\_
4. Percentage of rotary wing operation: \_\_\_\_\_
5. Percentage of fixed wing operation: \_\_\_\_\_
6. Percentage of inter-facility (hospital to hospital) operation: \_\_\_\_\_
7. If inter-facility transfer, are signed physician orders transported on board the aircraft with the patient? [ ] Yes [ ] No
8. Name of all medical facilities (hospital, etc.) the Applicant affiliated with: \_\_\_\_\_
9. Does the Applicant have a Medical Director? [ ] Yes [ ] No. If Yes, provide the Medical Director's name:  
\_\_\_\_\_
10. Does the Medical Director serve as an attending flight physician? [ ] Yes [ ] No
11. Limits of Professional Liability Insurance the Medical Director carries: \_\_\_\_\_
12. Does the Applicant have Standing Order Protocols? [ ] Yes [ ] No. If Yes, provide who they are written by:  
\_\_\_\_\_
13. Will the Applicant's staff include Attending Flight Physicians? [ ] Yes [ ] No
14. What is the minimum limit of liability of professional liability insurance the Applicant requires Attending Flight Physicians to carry? \_\_\_\_\_
15. How does the Applicant confirm the Medical Director's and Attending Flight Physician's insurance is in place?  
\_\_\_\_\_

If coverage is to include the Medical Director or Attending Flight Physicians, complete separate the Application for Physicians, & Surgeons Professional Liability Insurance.

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understand that information submitted herein becomes a part of my/our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by the Applicant (within 60 days of the proposed effective date).

\_\_\_\_\_  
Name of Applicant

\_\_\_\_\_  
Title (Officer, partner, etc.)

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date