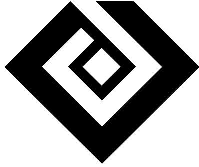

Return to:

OUTPATIENT PHYSICAL THERAPY AND REHABILITATION

(This application is supplemental to the Misc. Medical Professionals application.)

(Please note that this Supplemental Application must be completed for each facility/location providing outpatient rehabilitation for the impaired. The Misc. Medical Professionals Application must be completed and submitted with all Rehabilitation for the Impaired Supplemental Applications).

NAME OF FACILITY:____

ADDRESS: ____

Street City State/Zip County

LICENSING

1. Licensed by state of:____
2. License #: ____
3. Expiration Date:____
4. Has License ever been revoked, suspended, placed on probation or restricted in any way? ☐Yes ☐ No
   If YES, please explain: ____

FACILITY OPERATIONS

5. Fully describe the exact purpose of the operations, activities, services and professional procedures administered:
   ____
   ____
   ____
6. Present number of patients:
7. Age of patients:

   Number of over 65 ______________
   Between 50 & 65 ______________
   Between 25 & 49 ______________
   Between 18 & 24 ______________
   Under 18 ______________

8. The number of patients treated during the last three years are:

   20___ - # of patients treated _______

   20___ - # of patients treated _______

   20___ - # of patients treated _______

PATIENT / TREATMENT INFORMATION

9. Are medication or drugs given:

   a. Only under a physician's written orders? ☐ Yes ☐ No

   b. Only by authorized medical professionals? ☐ Yes ☐ No

   If the answer to a. or b. above is NO, please explain

   ____

10. Are drugs administered according to Federal Drug Enforcement Agency rules? ☐ Yes ☐No

11. Is a complete physician's examination required prior to admission or treatment? ☐ Yes ☐No

12. Is a complete medical history of each patient or client retained on premises? ☐Yes ☐ No

13. Are medical records released to third parties without the written consent of the patient? ☐ Yes ☐ No
    YES, please explain:____

14. Are full patient assessments completed and released to the patient's physician? ☐ Yes ☐ No

15. Are hot packs used in patient treatment? ☐ Yes ☐ No

16. Is a comprehensive explanation of diagnosis/treatment communicated to the patient? ☐ Yes ☐ No

STAFF

18. Total Emloyees _____________ #   Total Independent Contractors ______________#

(Complete job descriptions must accompany this application for those professionals indicated in Q. 18 above.)

19. Health Care Professionals

	Shift 1		Shift 2		Shift 3	
	Total Annual Hours	**# Employees/ Contractors**	**Total Annual Hours**	**# Employees/ Contractors**	**Total Annual Hours**	**# Employees/ Contractors**
Administrators						
Clerical						
Counselors						
Dieticians						
Medical Records						
Nurses / Nurse Aides						
Nurse Practitioner / Clinical Nurse Specialist						
Occupational Therapists						
Occupational Therapy Aide						
Pharmacists						
Physical Therapist						
Physical Therapy Aide						
Physician / Physician Assistant						
Psychologists						
Social Workers						
Speech & Hearing Therapists						

20. Please provide information requested for each Medical Director and/or Physician providing services at the applicants facility. (Attach copy of medical malpractice policy Declarations)

	Ins. Carrier & Effective Date	Policy Limits	State of Licensure	License Number	Employee or Contractor	Hours Per Month
Name - Medical Dir.						
Name - Physician						
Name - Pharmacist						

I DECLARE that the information contained in this supplement is true and that no material facts have been suppressed or misstated.

I UNDERSTAND that an incorrect or incomplete response could void my coverage.

____ ________________________

Signature of Applicant Date