

Supplemental Questionnaire for Medical Arts Schools



Instructions: Complete this supplement in its entirety. If a specific item is not applicable, please state N/A. If the space provided is insufficient, attach a separate sheet. Please note this supplement is part of the application and all warranties and statements contained therein apply to this supplement.

Name of Insured: _____

1. Does insured operate any outpatient/clinic operations? _____
If yes, describe services provided: _____

2. Please provide length of class: _____

3. Enclose copies of each course curriculum.

4. Provide a breakdown of total number of students annually by classification:
_____ # of EMT Basic; _____ # EMT Intermediate; _____ # Paramedic; _____ # LVN; _____ # RN
Describe other types of students _____ # _____; _____ # _____;
_____ # _____; attach a separate sheet, if
necessary, and provide the number of staff/instructors by professional categories:

5. Enclose a description of all externship programs offered and copies of contracts with the facilities where the programs are conducted.

6. If no contracts exist, does insured provide staff instruction to supervise students in the program, or does the facility supervise the activities?

Date

Applicant Signature/Title

Send submissions to: healthcare@iscmga.com