Pharmacist/Pharmacy Supplement

Note: Supplement must be dated and signed by owner, partner, officer, or administrator.

Please type or print in ink, and do not reduce when faxing.

1. Applicant Name: _____

2. Is the pharmacy owned by a pharmacist? ❒ Yes ❒ No

3. Does the pharmacist(s) mix any IV solutions or pills for compounding drugs? ❒ Yes ❒ No
   If yes, are solutions made from pre-mixed packages? ❒ Yes ❒ No
   If not, please explain: _____

4. Annual gross receipts estimated for next 12 months (complete all applicable categories):

   From Prescription Sales: $_____
   From Sundries Sales: $_____
   From Medical Equipment Sales *1 $_____
   From Medical Equipment Rental *1 $_____
   From In-Home I.V. Therapy*2 $_____
   Other: _____ $_____
   (Total receipts last 12 months: $_____) Total: $_____

   *1 Complete Products Sales or Equipment Rental Supplement

   *2 Complete Home IV Supplement

5. Total number of ALL staff: _____
   Number of Professional Staff: (E = Employed; C = Contracted)

E	C		E	C	
____	____	Pharmacists	____	____	Pharmacy Technicians
____	____	RN	____	____	LVN/LPN
____	____	Respiratory Therapists	____	____	Laboratory Technicians
____	____	Other: _____	____	____	Other: _____
____	____	Other: _____	____	____	Other: _____
____	____	Physicians			

Note: Physicians are required to carry own professional liability insurance at equal limits. Complete Physician Exposure Supplement.

6. Total payroll or remuneration paid to all staff: Est. next 12 months: $_____
   (employee or contract) Actual last 12 months: $_____

Send submissions to: healthcare@iscmga.com

7. **If Applicant is an Employed or Contract Individual**, give name and address of all employers, nature of employer's operations, name of direct supervisor, and describe your duties:

Does employer require you to carry the insurance being applied for? ❒ Yes ❒ No
Does employer carry own professional liability insurance? ❒ Yes ❒ No

8. Do you require staff to report all incidents (accidents) which might result in a liability claim AND are records of such reports kept on file by you? ❒ Yes ❒ No
If not, are you agreeable to instituting this procedure? ❒ Yes ❒ No

9. Do you rent, sell, or otherwise provide any equipment or products to others? ❒ Yes ❒ No
If yes, complete our Medical Products Sales or Equipment Rental Supplement.

10. Do you have any other premises or operations exposures not stated in this application, or do you have an interest in any other health care services businesses? ❒ Yes ❒ No
If yes, enclose complete description and underwriting/rating information including insurance coverage for that operation (Professional and General Liability), including carrier, limits, etc.: _____

Date

Applicant Signature/Title

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