

**LOUISIANA PATIENT'S COMPENSATION FUND  
HOSPITAL & NURSING HOME APPLICATION  
(RENEWAL FOR THOSE WITH PRIMARY INSURANCE)**

**\*\*\*IF COVERAGE IS IN PLACE FOR A CORPORATION, PLEASE PROVIDE A SEPERATE CERTIFICATE OF INSURANCE AND A CORPORATION APPLICATION (PCF9), WHICH CAN BE FOUND ON OUR WEBSITE.  
<http://www.doa.la.gov/Pages/pcf/Index.aspx>**

**Must advise the PCF of any offsite entities or multiple practice locations for which coverage is provided along with the address for each location and proof of underlying coverage.**

**EMPLOYEES AS ADDITIONAL INSURED:** Please see below inclusions/exclusions then complete the proper form and include proof of underlying coverage.

**INCLUSIONS:** *Employed Allied Healthcare Providers.*

**EXCLUSIONS:** *This does not include those who require a PCF surcharge, such as, NP's, PA's, CNS', CRNA's, etc.*

**PCF RESERVES THE RIGHT TO DENY COVERAGE FOR THE FOLLOWING:**

- (1) Injury arising out of a criminal act, including but not limited to sexual abuse or molestation, fraud committed by the insured or any person for whom the insured is legally responsible, and battery.
- (2) Third (3<sup>rd</sup>) party claims filed by an injured party that was not a patient of the health care provider.
- (3) Services or treatment rendered as a licensed provider in states other than Louisiana, even if the underlying insurer provides coverage for same.

**Date**                      **Printed Name of Insured**

**Signature of Insured -- NOT VALID WITHOUT SIGNATURE**

Any questions regarding this form may be emailed to: [pcf-surcharge@la.gov](mailto:pcf-surcharge@la.gov)

**A PRINTED, SIGNED COPY OF THIS FORM MUST BE MAILED/FAXED TO PCF.**