

**LOUISIANA PATIENT'S COMPENSATION FUND
CORPORATION APPLICATION**
(for those with underlying self-insurance and primary insurance)

NAME AND PHYSICAL ADDRESS OF CORPORATION
(Please designate whether it is APMC, AMC APC, INC, LLC, LLP, etc.)

DATES OF ENROLLMENT APPLYING FOR: _____

**LIST ALL LOUISIANA HEALTHCARE PROVIDERS WHO ARE ELIGIBLE FOR ENROLLMENT BY
PAYMENT OF A SURCHARGE IN ACCORDANCE WITH THE PCF RATE MANUAL.**

**THIS INCLUDES THOSE WHO ARE EMPLOYED BY/AT THE ABOVE CORPORATION (INCLUDING
YOURSELF IF THE CORPORATION IS THE SAME AS YOUR NAME) AND ANY ADDITIONAL
LOCATIONS IN LOUISIANA OR HEALTH CARE FACILITIES IN LOUISIANA OWNED BY THE
CORPORATION TO BE INCLUDED IN THE CORPORATE COVERAGE WITH THE PCF:**

Name	Title and/or Association

NOTE:

No charge will be made to cover such entity if all shareholders/partners and professional employees are qualified with the PCF. Otherwise a charge of 20% of each class rate will be made for shareholders/partners and employees not qualified in the PCF. A separate Certificate of Insurance is required that lists all enrolled health care providers in the Corporation/Partnership.

Does the corporation own other healthcare related facilities outside of LA (Please note that this is for informational purposes only and that the PCF cannot provide coverage for healthcare facilities outside of LA)?

YES / NO please circle

If yes, in what states? _____

I further certify that the appropriate security (proof of financial responsibility) is in place and current at _____

SIGNATURE OF AUTHORIZED REPRESENTATIVE: _____

DATE: _____

CONTACT PERSON AND PHONE #: _____