Professional Liability Solutions, LLC

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APPLICATION FOR CLINICS (MEDICAL, DENTAL, PUBLIC HEALTH, MENTAL HEALTH, OTHER)
PROFESSIONAL LIABILITY INSURANCE

NOTICE: The policy for which application is made provides coverage on a "CLAIMS MADE" basis. Please read the policy carefully.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. (a) Full name of Applicant: _____

   (b) Principal practice address: _____
   (Street) (County)

   _____
   (City) (State) (Zip)

   (c) Location: Stand alone _____ Hospital _____ School _____ Correctional Facility _____ Other _____

   (d) (i) Phone: _____

   (ii) E-Mail Address: _____ (iii) Website Address: _____

   (e) Date Established: _____
   Attached a proforma business plan if the Applicant is newly established.

2. Applicant is a:

   ☐ professional corporation ☐ joint venture
   ☐ limited liability company ☐ professional association
   ☐ other _____ ☐ partnership

3. Name(s) of all partners or members of the clinic who provide professional services: _____

   _____

4. Does any owner, partner or director operate or administer, wholly or in part, any hospital, nursing home or other institution where medical services are rendered? ..... ☐ Yes ☐ No
   If Yes, provide details, including name, location, size and number of beds. _____

   _____

5. Is the Applicant a "Covered Entity" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule? ..... ☐ Yes ☐ No
   If Yes,
   (a) Has the Applicant implemented procedures to comply with the HIPAA Privacy Rule?..... ☐ Yes ☐ No
   (b) Provide the name and title of the Applicant's Privacy Officer. _____
   Our Business Associate Agreement is available at www.markelcorp.com. This is the only Business Associate Agreement we will recognize.

II. OPERATIONS

1. Days/hours of operation: _____

2. (a) Provide the name and specialty of the Applicant's Medical Director: _____
   (b) Does the Applicant's Medical Director have direct patient contact? ..... ☐ Yes ☐ No
   (c) Is the Applicant's Medical Director full-time or part-time? _____

3. Applicant's professional specialty: _____

4. Provide the percentage of patients/clients:

Bariatrics	____%	Holistic medicine	____%	Sleep Disorders	____%
Communicable Disease	____%	Obstetrical	____%	Stress Testing	____%
Correctional Medicine	____%	Oncology	____%	Students	____%
Dental	____%	Pain Management	____%	Substance Abuse	____%
Disability Evaluation	____%	Pediatric	____%	Surgical	____%
Family Planning	____%	Physical Rehabilitation	____%	Urgent Care	____%
Free Clinic	____%	Psychiatric	____%		
Hemodialysis	____%	Research or Experimental	____%		

5. List all Locations where Applicant is registered and licensed to operate:

   Location 1: _____

   Location 2: _____

   Location 3: _____

   Location 4: _____

6. Name(s) and location(s) of any hospital or medical facility that the Applicant refers in practice: _____

   _____

7. Has the Applicant's state license, registration or certification, or certification for federal reimbursement ever been limited, revoked, suspended, refused, cancelled or voluntarily surrendered?..... ☐ Yes ☐ No
   If Yes, provide details._____

8. List all accreditations and association memberships held by Applicant's facility and include a copy of the most recent report:_____

9. Does the Applicant currently participate in or plan to participate in a state patient compensation fund, health care stabilization fund or other governmentally established malpractice liability funding mechanism?..... ☐ Yes ☐ No

10. Is the Applicant "deemed" under the Federal Tort Claims Act ("FTCA")? ..... ☐ Yes ☐ No
    If Yes, what percentage of services are provided under the FTCA? _____

11. Does the Applicant or any of its employees or independent contractors provide services for correctional facilities, such as a jail, detention center, prison, etc.?..... ☐ Yes ☐ No

12. Applicant's Gross Revenues:

	Last Twelve Months	Next Twelve Months
Fee for Service	$_____	$_____
Medicare/Medicaid Funds	$_____	$_____
Research	$_____	$_____
Other (describe)	$_____	$_____
TOTAL GROSS REVENUES	$_____	$_____

13. Number of outpatient/client visits:

	Last Twelve Months	Next Twelve Months
Clinics	_____	_____
Laboratory	_____	_____
X-ray/Imaging	_____	_____
Pharmacy	_____	_____
TOTAL VISITS:	_____	_____

    NOTE: If Applicant provided services for correctional facilities, provide number of inmates: _____

14. Does the Applicant maintain any beds for overnight occupancy:

    (a) On the Applicant's premises?..... ☐ Yes ☐ No
    If Yes,
    (i) No. of beds: ____
    (ii) Attach a copy of license and an explanation including protocols for on site 24 hour staffing.

(b) Off the Applicant's premises? ..... ☐ Yes ☐ No
If Yes,
(i) No. of beds: ____
(ii) Attach a copy of license and an explanation including protocols for on site 24 hour staffing.

III. STAFF

1. Indicate the number of professional employees, independent contractors and volunteers. If None, state None.

	Employees		Independent Contractors		Volunteers	
	Full-Time	**Part-Time**	**Full-Time**	**Part-Time**	**Full-Time**	**Part-Time**
Physicians: No surgery (other than incision of boils, suturing of skin) or obstetrical procedures						
Physicians: Minor surgery or obstetrical procedures not constituting major surgery						
Anesthesiologists						
Obstetrics-Gynecologists						
Oncologists						
Ophthalmologists						
Urologists						
Dentists						
Chiropractors						
Nurse Anesthetists						
Nurse Practitioners						
Optometrists						
Pharmacists						
Physician Assistants						
Podiatrists						
Psychologists						
RNs/LPNs/LVNs						
Social Workers						
Other(describe):						

NOTE: If the Applicant requires any of the above to be Insureds, submit a separate application for each such individual.

2. Are all of the above persons licensed in accordance with applicable state and federal regulation?..... ☐ Yes ☐ No
If No, attach explanation.

3. Do all professional staff maintain a Professional Liability Insurance Policy? ..... ☐ Yes ☐ No
If Yes, what are the minimum limits of liability that the Applicant requires?
$_____each claim / $_____ aggregate

IV. PROFESSIONAL SERVICES

1. Does the Applicant's employees or independent contractors:
(a) Perform any minor surgery other than incision of boils and superficial abscesses or suturing skin and superficial fascia? ..... ☐ Yes ☐ No
If Yes, list all minor/invasive procedures _____

_____

(b) Perform any anti-aging procedures, including Botox or other injectables? ..... ☐ Yes ☐ No
If Yes, complete a Supplement for Medical Spa/Anti-Aging Clinics (SM31001).

(c) Perform abortions and/or menstrual extractions? ..... ☐ Yes ☐ No
If the Applicant provides pregnancy termination complete a Supplement for Abortion Centers (SM31002)

(d) Perform any experimental procedures or research testing? ..... ☐ Yes ☐ No
If Yes, are they FDA approved? ..... ☐ Yes ☐ No
If No, attach a description.

(e) Perform any chelation therapy services? ..... ☐ Yes ☐ No
If Yes, explain: _____

(f) Administer anesthesia other than topical or local infiltration? ..... ☐ Yes ☐ No
If Yes, attach detailed explanation.

(g) Use drugs for weight reduction for patients? ..... ☐ Yes ☐ No
If Yes, attach list of drugs used and percentage of practice devoted to weight reduction; frequency and duration of prescriptions or weight reduction drugs and quantity dispensed.

(h) Administer any methadone treatment? ..... ☐ Yes ☐ No
If Yes,
(i) Provide the number of treatments during the:
Last 12 months _____ Next 12 months _____
(ii) Attach a description of treatment and controls used.

(i) Provide teleradiology services? ..... ☐ Yes ☐ No
If Yes, provide description of services and for whom services are provided._____

(j) Offer professional advice to the public via the internet, newspapers or broadcasts? ..... ☐ Yes ☐ No
If Yes, provide details._____

(k) Advertise professional services in any manner other than a simple listing in a telephone directory? ..... ☐ Yes ☐ No
If Yes, attach a copy of all advertisements.

2. Does the Applicant use a collection agency: ..... ☐ Yes ☐ No
If Yes,
(i) Name of agency: _____
(ii) Does the agency have authority to file a collection suit on behalf of the Applicant?..... ☐ Yes ☐ No

V. CLAIMS AND HISTORY

1. Has the Applicant or any of its employees ever:
(a) Been the subject of disciplinary or investigatory proceedings or reprimand by a licensing, administrative or governmental agency?..... ☐ Yes ☐ No
(b) Been convicted for an act committed in violation of any law or ordinance including traffic offenses? ..... ☐ Yes ☐ No
If Yes, provide details._____

_____

(c) Been evaluated or treated for alcoholism or drug addiction or mental or mental or emotional disorders? ..... ☐ Yes ☐ No
If Yes, provide details._____

_____

(d) Had any professional license or license to prescribe or dispense narcotics been denied, limited, refused, suspended, revoked, renewal refused or accepted only on special terms or has the Applicant or any of its employees voluntarily surrendered any professional license? ..... ☐ Yes ☐ No
If Yes, provide details._____

2. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance?..... ☐ Yes ☐ No
If Yes, how many? _____

3. Has any claim or suit for malpractice ever been made against the Applicant or any person proposed for this insurance that has not been reported to the Applicant's current or prior insurer?..... ☐ Yes ☐ No
If Yes, explain._____

_____

4. Is the Applicant or any person proposed for this insurance aware of any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice claim or suit?.. ☐ Yes ☐ No
If Yes, how many? _____

5. Has any insurer cancelled, rescinded, nonrenewed or declined any similar insurance for the Applicant, its predecessors, subsidiaries, affiliates, employees and/or for any other person or entity proposed for his insurance in the last five years?..... Yes [ ] No [ ]
If Yes, attach a copy of such insurer's notice.

6. List prior Professional Liability Insurance for each of the last five (5) years, including the current year:
If None, check here. [ ]

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

7. List prior General Liability Insurance for each of the last five (5) years, including the current year:

Ins Company	Limits of Liability	Premium	Eff./Exp. Dates	Claims Made or Occurrence Form	Retroactive Date

VI. GENERAL LIABILITY (To be completed by the Applicant if applying for General Liability)

1. Complete the following for each of the Applicant's facilities:

Location Number	Name of Facility	Address	Description of Facility	Does the Applicant Maintain a Garage? (Yes/No)	Is There an Adjacent Exposure? (Yes/No)
1					
2					
3					

2. Complete the following for each of the Applicant's locations:

	Location 1	Location 2	Location 3	Location 4
Square Footage*				
Year Built				
Year Remodeled				
Number of Stories				
Type of Construction (frame, brick, concrete)				
Percentage of Building Occupied by Applicant				
Other occupants? (Yes/No)				

*Include square footage of parking facilities if owned or rented by the Applicant.

3. Are all of the Applicant's locations equipped with:
   (a) Complete Sprinkler System? ..... [ ] Yes [ ] No
   (b) At least two clearly marked exits on each floor? ..... [ ] Yes [ ] No
   (c) Self-closing fire doors on each floor? ..... [ ] Yes [ ] No

(d) Automatic fire alarm system connected to a local fire department? ☐ Yes ☐ No
(e) Smoke detectors? ☐ Yes ☐ No
(f) Emergency electrical system? ☐ Yes ☐ No
(g) Heat sensors? ☐ Yes ☐ No
(h) Fire escape(s)? ☐ Yes ☐ No
(i) Posted emergency evacuation procedures? ☐ Yes ☐ No
(j) Properly maintained fire extinguishers? ☐ Yes ☐ No

If any of the above are answered No, provide details by attachment.

4. Does the Applicant have a written safety program in place? ☐ Yes ☐ No
If Yes, attach a copy of the written safety program.

5. Does the Applicant have written procedures for incident reporting? ☐ Yes ☐ No

6. Do any of the Applicant's locations have any:
(a) Exposure to flammables, explosive, chemicals? ☐ Yes ☐ No
(b) Catastrophe exposure? ☐ Yes ☐ No
(c) Exposure to radioactive materials? ☐ Yes ☐ No

7. Do any of the Applicant's operations involve storing, treating, discharging, applying, disposing, or transporting hazardous materials? ☐ Yes ☐ No

8. Does the Applicant sell or lease any medical equipment or products to patients/clients or others in connection with Applicant's operation? ☐ Yes ☐ No
If Yes, Total Annual Sales $_____
Total Annual/Lease Rental Receipts $_____

9. Does the Applicant:
(a) Loan or rent machinery or equipment to others? ☐ Yes ☐ No
(b) Own any elevators or escalators? ☐ Yes ☐ No
(c) Own or rent any parking facility? ☐ Yes ☐ No
(d) Provide any recreational facility? ☐ Yes ☐ No
(e) Have a swimming pool on the premises? ☐ Yes ☐ No
(f) Sponsor any sporting or social events? ☐ Yes ☐ No

10. Has any claim for General Liability ever been made against any person(s) or entity(ies) proposed for this insurance? ☐ Yes ☐ No
If Yes, answer the following:
Provide three year loss history for claims under $100,000 Loss and Expense and ten years for claims $100,000 and greater. Attach further sheets if needed.

Date of Occurrence	Date Claim Made	Description of Loss	Amount of Loss Reserved and Paid	Amount of Expenses Reserved and Paid	Open (O) or Closed (C)

11. Is (are) any person(s) or entity(ies) proposed for this insurance aware of any fact, circumstance or situation which may result in a General Liability claim, such that would fall under the proposed insurance? ☐ Yes ☐ No
If Yes, provide details for each incident._____

VII. ADDITIONAL INFORMATION

As part of this Application attach the following:

1. A CV of Medical Director including specialty and board certification.
2. Five (5) years of currently valued Professional Liability Insurance and General Liability Insurance claim runs from current and prior insurers or complete a Supplemental Claim Information form (SM6236) for each claim.
3. A list of any activities or procedures performed that are not otherwise described in this Application.

4. Credentialing, Risk Management protocols.
5. Most recent annual financial statements, both a balance sheet and a revenue and expense statement. If the Applicant is newly established attached proforma financial statements.
6. Complete an Additional Insured Supplement for any additional insured that coverage is being requested for under General Liability Coverage.

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE “CLAIMS” THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Extended Reporting Period option is exercised in accordance with the terms of the policy.

The underwriting manager, Company and/or affiliates thereof are authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which the underwriting manager, Company and/or affiliates thereof receives notice is on file with the underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the underwriting manager, Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

I/We warrant to the Company, that I/We understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I/We authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

Must be signed by the Applicant within 60 days of the proposed effective date.

Name of Applicant	Title
Signature of Applicant	Date

Notice to Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties.

ADDITIONAL EXPLANATIONS

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ALTERNATIVE THERAPIES SUPPLEMENT

PLEASE READ CAREFULLY THE STATEMENTS AT THE END OF THIS APPLICATION.

1. APPLICANT PROFESSIONAL SERVICES & MEDICAL PRACTICE

a) Acupuncture, for analgesia, asthma, nicotine addiction, headache, low back pain (circle each that apply) ... Yes No
If yes, do you only use disposable needles? ... Yes No
(If no, attach details.)
Do you use lasers on the acupuncture points? ... Yes No
(If yes, we will need a copy of your training - please attach.)

b) Electro acupuncture ... Yes No

c) Acupressure ... Yes No

d) Ayurvedic Medicine ... Yes No

e) Biofeedback ... Yes No

f) Chelation Therapy ... Yes No
If yes, indicate No. of annual treatments _____ and what is your certification, or attach a copy of your training _____ date certified ___/___/___.

g) Chiropractic ... Yes No
If yes, do you perform manipulation under anesthesia? ... Yes No

h) Homeopathy ... Yes No

i) Hypnosis ... Yes No

j) Invasive Procedures **(If yes, attach details.)** ... Yes No

k) Light Therapy ... Yes No

l) Massage Therapy ... Yes No

m) Megavitamins ... Yes No
If yes, do you sell these products? ... Yes No
(If yes, attach details.)

n) Moxibustion, direct ... Yes No

o) Naturopathy ... Yes No

p) Nutritional Supplements ... Yes No
If yes, do you sell these products? ... Yes No
(If yes, attach details.)

q) Osteopathy ... Yes No

r) Pharmacological & Biological Treatments ... Yes No
If Chelation Therapy, refer to Item (f.)
(If Others, attach details.)

s) Reflexology ... Yes No

t) Reiki ... Yes No

u) Therapeutic Touch ... Yes No

v) Traditional Chinese Medicine ... Yes No

w) Western Herbalism ... Yes No
If yes, do you sell these products? ... Yes No
(If yes, attach details.)

x) Other (If yes, attach details.) ... Yes No

2. TESTING OPERATIONS

a) Do you participate in any nutritional or pharmaceutical testing programs? Yes No. If yes, are they FDA approved? Yes No **(If No, attach details.)**

3. ADDITIONAL INFORMATION

Please attach: **Copy of brochure**, or other descriptive literature and **Resume**

I understand information submitted herein becomes a part of my General Application and is subject to the same representation and conditions.

Name of Applicant _____ Title (Officer, partner, etc.) _____

Signature of Applicant _____ Date _____

*Signing this form does not bind the applicant or the Company or the Underwriting Manager to complete the insurance.

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SUPPLEMENT FOR MEDICAL SPA/ANTI-AGING CLINICS

(USE WITH APPLICATION FOR CLINICS (MEDICAL, PUBLIC HEALTH, DENTAL, ETC.) PROFESSIONAL LIABILITY INSURANCE (SM-30006))

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

I. GENERAL INFORMATION

1. Full name of Applicant: _____

II. OPERATIONS

1. What is the professional specialty of the clinic? _____

2. (a) Provide a list of the Applicant's Medical Director(s): _____

   (b) Attach a CV for each of the Applicant's Medical Directors and a description of their duties.

3. Provide the percentage of the Applicant's patients/clients in the following categories:

Acupuncture	_____%	Plastic Surgery	_____%
Beauty Shop (nails, hair, facials)	_____%	Research or Experimental	_____%
Chelation Therapy	_____%	Sclerotherapy	_____%
Dental	_____%	Surgical	_____%
Dermatology	_____%	Weight Control	_____%
Hormone Therapy	_____%	Other (specify)	
Massage	_____%	_____	_____%
Medical Spa	**_____%**	**TOTAL**	**100**%

4. Applicant's practice is run by:

___ Doctor ___ Plastic Surgeon ___ Other – describe _____
___ Dentist ___ Nurse
___ Dermatologist ___ Administrator

III. PROFESSIONAL SERVICES

1. List all manufactured equipment and drugs used in the Applicant's practice and the purpose for which each is used. Attach separate sheet if necessary:

Equipment/Drug	Purpose	Used only as approved by the FDA? (Yes or No)	If No, describe off-label usage.

2. Does the Applicant take before and after pictures of every patient?..... | Yes | No
   If No, explain. _____

3. Must all clients sign a patient consent form specific to the procedures to be performed prior to treatment?..... Yes | No
   If No, explain. _____

IV. PROCEDURES

1. Botox Injections

Does the Applicant perform Botox Injections? ..... Yes No

If Yes, complete the following:

(a) Total number of Botox Injections: .....(i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Botox Injections?.....

___ Physician ___ Physician's Assistant ___ Nurse

___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(c) Have all staff performing Botox Injections:

(i) Received a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient?..... Yes No

(ii) Performed a minimum of ten procedures on live patients?..... Yes No

(d) Does the Applicant have a physician available for consultation and complications? ..... Yes No

If Yes,

(i) Has this physician completed a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient?..... Yes No

(ii) Does the physician have Medical Malpractice Liability Insurance for this activity? ..... Yes No

If No, submit a separate application for each physician to be included.

2. Chemical Peels

Does the Applicant perform Chemical Peels? ..... Yes No

If Yes, complete the following:

(a) Total number of Chemical Peels with solution strength <30%:..(i) Past 12 months: _____ (ii) Next 12 months: _____

(i) Who performs Chemical Peels with solution strength <30%:

___ Physician ___ Physician's Assistant ___ Nurse

___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(ii) Have all staff performing Chemical Peels with solution strength <30% received a minimum of eight hours training specifically for this procedure including anatomy, physiology, skin typing, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? ..... Yes No

(b) Total number of Chemical Peels with solution strength >30%:..(i) Past 12 months: _____ (ii) Next 12 months: _____

(i) Who performs Chemical Peels with solution strength >30%:

___ Physician ___ Physician's Assistant ___ Nurse

___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(ii) Are all staff performing Chemical Peels with solution strength >30% licensed physicians with a specialty of Dermatology or Plastic Surgery? ..... Yes No

3. Dermal Fillers

Does the Applicant perform Dermal Fillers (Artefill, Collagen, Hylaform, Restylane)? ..... Yes No

If Yes, complete the following:

(a) Total number of Dermal Fillers: .....(i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Dermal Fillers?

___ Physician ___ Physician's Assistant ___ Nurse

___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(c) Have all staff performing Dermal Fillers:

(i) Received a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? ..... Yes No

(ii) Performed a minimum of five procedures on live patients? ..... Yes No

Dermal Fillers continued

(d) Does the Applicant have a physician available for consultation and complications? ..... Yes No

If Yes,

(i) Has this physician completed a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? ..... Yes No

(ii) Does this physician have Medical Malpractice Liability Insurance for this activity? ..... Yes No
If No, submit a separate application for each physician to be included.

(e) Does the Applicant

(i) Use only dermal fillers approved by the FDA? ..... Yes No
If No, explain: _____

(ii) Disclose off-label use to all patients receiving such treatment on the patient consent form? ..... Yes No

4. Laser Skin Treatments

Does the Applicant perform Laser Skin Treatments including Laser Hair Removal, IPL (Intense Pulse Light Treatments), Acne Blue Light Treatments, and Laser Vein Treatments? ..... Yes No

If Yes, complete the following:

(a) Total number of Laser Skin Treatments: .....(i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Laser Skin Treatments Injections?

___ Physician ___ Physician's Assistant ___ Nurse
___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(c) Does the Applicant comply with the following standards of practice:

(i) Individuals are trained in laser physics, tissue interaction, laser safety, clinical application, pre-operative care, and post-operative care of the laser patient. ..... Yes No

(ii) Prior to the initiation of any patient care activity the individual has read and sign the clinic's policies and procedures regarding the safe use of lasers. ..... Yes No

(iii) Continuing education of all licensed medical professionals is mandatory and made available with reasonable frequency (including outside the office setting) to help insure adequate performance. (Specific credit hour requirements will be determined by the state and/or individual clinic.) ..... Yes No

(iv) A minimum of ten procedures of precepted training is required for each laser procedure and laser type to assess competency. Participation in all training programs, acquisition of new skills and number of hours spent in maintaining proficiency is well documented. ..... Yes No

(v) After demonstrating competency to act alone, the designated licensed medical professional may perform limited laser treatments on specific patients as directed by the supervising physician. ..... Yes No

(d) Does the Applicant comply with the following standards of practice for non-physicians use of laser related technology:

(i) Any physician who delegates a procedure to a non-physician must be qualified to do these laser procedures themselves by virtue of having received appropriate training in physics, safety, surgical techniques, pre and post operative care, and be able to handle the resultant emergencies or sequela. ..... Yes No

(ii) Any licensed medical professional employed by a physician to perform a procedure has received appropriate documented training and education in the safe and effective use of each system and are a licensed medical professional in the state of practice. ..... Yes No

(iii) A properly trained and licensed medical professional carries out these specifically designed procedures only under the direct, on-site physician supervision and following written procedures. ..... Yes No

(iv) The supervising physician is available on-site to respond to any untoward event that may occur. Ultimate responsibility lies with the supervising physician. ..... Yes No

5. Massage Therapy/Cellulite Treatments

Does the Applicant perform Massage Therapy/Cellulite Treatments? ..... Yes No

If Yes, complete the following:

(a) Total number of Massage Therapy / Cellulite Treatments: .....(i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Massage Therapy / Cellulite Treatments?

___ Physician ___ Physician's Assistant ___ Nurse
___ Massage Therapist ___ Nurse Practitioner ___ Other-describe: _____

Massage Therapy/Cellulite Treatments continued

(c) Are all staff performing Massage Therapy / Cellulite Treatments licensed, registered or certified according to state requirements? ..... Yes No
If No, explain. _____

6. Mesotherapy and/or Lipodissolve

Does the Applicant perform Mesotherapy and/or Lipodissolve at this clinic? ..... Yes No

If Yes, complete the following:

(a) Total number of Mesotherapy/Lipodissolve Treatments: .....(i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Mesotherapy/Lipodissolve at this clinic?

Physician Physician's Assistant Nurse
Dentist Nurse Practitioner Other-describe: _____

(c) Are all staff performing Mesotherapy and/or Lipodissolve licensed physicians with a minimum of eight hours training to perform Mesotherapy and/or Lipodissolve including anatomy, physiology, contraindications, potential complications, and performance of at least one procedure on each part of the anatomy for which coverage is desired? ..... Yes No

7. Microdermabrasions

Does the Applicant perform Microdermabrasions? ..... Yes No

If Yes, complete the following:

(a) Total number of Microdermabrasions: .....(i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Microdermabrasion:

Physician Physician's Assistant Nurse
Dentist Nurse Practitioner Other-describe:

(c) Have all staff performing Microdermabrasion treatments received a minimum of eight hours training including specific training for the equipment being used, skin typing, contraindications, potential complications, and performance of at least one procedure on a live patient? ..... Yes No
If No, explain: _____

8. Micropigmentation / Permanent Makeup

Does Applicant perform Micropigmentation / Permanent Makeup? ..... Yes No

If Yes, complete the following:

(a) Total number of Permanent Makeup / Micropigmentations: ...(i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Permanent Makeup / Micropigmentations:

Physician Physician's Assistant Nurse
Dentist Nurse Practitioner Other-describe: _____

(c) Have all staff performing Permanent Makeup / Micropigmentation treatments received a minimum of eight hours training including specific training for the equipment being used, skin typing, contraindications, potential complications, and performance of at least one procedure on a live patient? ..... Yes No
If No, explain: _____

9. Sclerotherapy Injections

Does the Applicant perform Sclerotherapy Injections? ..... Yes No

If Yes, complete the following:

(a) Total number of Sclerotherapy Injections: .....(i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Sclerotherapy Injections?

Physician Physician's Assistant Nurse
Dentist Nurse Practitioner Other-describe: _____

(c) Are all staff performing Sclerotherapy Injections physicians who have received a minimum of eight hours training specific for this procedure, including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of a minimum of one procedure on a live patient? ..... Yes No

10. Tattoo Removals

Does the Applicant perform Tattoo Removals? ..... Yes No

If Yes, complete the following:

(a) Total number of Tattoo Removals: .....(i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Tattoo Removal:

Physician Physician's Assistant Nurse
Dentist Nurse Practitioner Other-describe: _____

(c) Are all staff performing Tattoo Removal licensed physicians who comply with the following standards of practice:

(i) Physicians are trained appropriately in laser physics, tissue interaction, laser safety, clinical application, pre-operative care, and post-operative care of the laser patient..... Yes No

(ii) Prior to the initiation of any patient care activity the physician has read and signed the clinic's policies and procedures regarding the safe use of lasers..... Yes No

(iii) Continuing education of all physicians is mandatory and made available with reasonable frequency (including outside the office setting) to help insure adequate performance. (Specific credit hour requirements will be determined by the state and/or individual clinic.) ..... Yes No

11. Surgical or Minor Surgical / Invasive Procedures

Does the Applicant perform surgical or minor surgical/invasive procedures? ..... Yes No

If Yes, complete the following:

(a) Total number of surgical procedures: .....(i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs surgical and/or minor surgical/invasive procedures?

_____

(c) Provide a complete list of all surgical and minor surgical/invasive procedures being performed:
Attach a separate sheet if necessary.

_____

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by director, executive officer, partner or equivalent within 60 days of the proposed effective date.

_____ _____
Name of Applicant Title (Officer, partner, etc.)

_____ _____
Signature of Applicant Date