



Allied Healthcare Professional Liability and General Liability:

ATHLETIC AND PHYSICAL TRAINING/THERAPIST SUPPLEMENTAL APPLICATION

PLEASE INDICATE ALL SERVICES PROVIDED BY THE APPLICANT:

- Athletic trainers
- Personal trainers/fitness instructors
- Corrective therapists
- Physical therapists
- Occupational therapists
- Rehabilitation therapists

1. Name of applicant: _____
2. Is the applicant or facility staff certified in Cardio-Pulmonary Resuscitation (CPR) and first aid? Yes No
3. Percentage of services provided to minors (6-18 yrs) : ____%
4. Does any person for whom coverage is sought conduct blood analysis or stress testing services? Yes No
5. Does any person for whom coverage is sought provide Integumentary services (wounds/burns) or services to children under age six (6) Yes No
6. Does any person for whom coverage is sought work with celebrities, professional athletes, Division 1 college athletes or recruits or other high profile clients? Yes No
If "Yes", % of services for high profile clients? _____
7. If applicant is an athletic trainer or provides physical therapy services, are these services provided only under a physician's direction? Yes No N/A
If "No", please explain: _____
8. (a) If physical therapy services are provided, are formal policies and procedures followed for assessing quality of care, risk management, infection control and patient safety? Yes No N/A
(b) If "Yes," are these policies and procedures reviewed regularly for effectiveness? Yes No
9. Does the applicant provide more than 10% of services in a nursing home or inpatient hospital setting? Yes No
10. If physical therapy services are provided, does the applicant follow formal policies and procedures for proper documentation of patient/client records and proper communication of clinical information to professionals involved in the treatment of patients/clients? Yes No N/A
11. Does the applicant own/operate a training, therapy or fitness facility? Yes No
(a) If yes, are safety inspections regularly performed on the facility and all equipment? Yes No N/A
12. If the applicant is a corrective therapist, are all services performed only with a physicians order? Yes No N/A
13. If the applicant provides occupational therapy services, do these services include driver rehabilitation services? Yes No N/A
14. If the applicant provides occupational therapy services, does the applicant require a physician's sign off before a patient/client returns to work? Yes No N/A
15. If applicant is a personal trainer, are martial arts or combat training services offered? Yes No N/A

This supplemental application is incorporated into and is deemed a part of the other application(s) submitted in connection with the requested insurance. Any and all notices and representations included in such other application(s) are incorporated by reference in this supplemental application as though fully set forth herein.

Applicant's Signature _____ Title _____ Date _____
(Principal, Partner or Officer)

Print Name _____

This document does not amend, extend or alter the coverage afforded by the policy. For a complete understanding of any insurance you purchase, you must first read your policy, declaration page and any endorsements and discuss them with your broker. A specimen policy is available from an agent of the company. Your actual policy conditions may be amended by endorsement or affected by state laws.