



COLONY INSURANCE COMPANY

9201 FOREST HILL AVE., SUITE 200, RICHMOND, VA 23233 PHONE: (800) 577-6614 FAX: (804) 327-3172

ALLIED MEDICAL ACCUPUNCTURISTS SUPPLEMENTAL APPLICATION SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION:

1. Square feet of total office space (all locations): _____

2. Does your state license or register acupuncturists? No Yes

3. Applicant's license number: _____
Expiration Date: ___/___/___

4. Are you NCCA certified? No Yes

If yes, please provide: Certification date ___/___/___
Certification # _____
Expiration date of certificate ___/___/___.

Are you a member of AAAOM? No Yes
Current Member No. _____

5. Describe professional training and experience or attach a current resume:

6. Indicate professional societies or associations in which applicant is a member:

7. Is applicant associated with or does applicant work for a physician or surgeon? No Yes

8. Indicate percent of time spent in the following work locations:
___ % Administrative Office ___ % Patient Home
___ % Classroom ___ % Professional Office (specify profession) _____
___ % Nursing Home ___ % Other (specify) _____
___ % Outpatient Clinic

9. Provide number of patient or client encounters:

	Number of Client Contacts Last 12 Months	Number of client Contacts Next 12 Months
Type of Client Contact		
Clinic		
Office		
Pro Bono		
Total number of contacts		

10. Do you perform or assist in any surgical procedures? No Yes

11. List ALL surgical procedures performed (including minor surgery)

Is anesthesia (other than topical or by means of local infiltration) administered by either yourself or others? _____

Applicant's Signature & Date _____/_____/_____



COLONY INSURANCE COMPANY

9201 FOREST HILL AVE., SUITE 200, RICHMOND, VA 23233 PHONE: (800) 577-6614 FAX: (804) 327-3172

ALLIED MEDICAL GENERAL APPLICATION

APPLICANT'S INFORMATION

APPLICANT NAME:			
MAILING ADDRESS:			
COUNTY:		DATE ESTABLISHED:	
INSPECTION CONTACT:		PHONE NUMBER:	
Type of Enterprise: <input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Non-Profit <input type="checkbox"/> For Profit <input type="checkbox"/> Joint Venture <input type="checkbox"/> Other: _____			
Estimated receipts/operating budget for the next 12 months:			
Estimated payroll for the next 12 months:			
Full description of services rendered:			

Current Insurance:

Has applicant had previous insurance for this enterprise? No Yes
If yes, complete the following:

General Liability

Professional Liability

Current Carrier		Current Carrier	
Policy term		Policy term	
Premium		Premium	
Deductible		Deductible	
Limits		Limits	
Occurrence or Claims Made		Occurrence or Claims Made	

During the past five (5) years, have any claims been presented to your current or prior insurance carrier or to you? No Yes
If yes, complete the following:

Date of loss	
Current reserve or amount paid	
Description of loss	
Date of loss	
Current reserve or amount paid	
Description of loss	

Has applicant, or any other person for whom insurance is being requested, aware of any circumstances, which may result in a claim?
If yes, provide full details.

No Yes

Has any license or accreditation ever been suspended, denied or revoked?

No Yes

Of what professional association(s) is Insured a member in good standing? _____

Staff:	Full Time	Part Time	Contracted/Employed
Administrators			
MD/Physicians			
Nurses			
Homemakers/Nurse Aids			
Psychologists			
Counselors			
Therapists			
Students or volunteers			
Other (specify)			

Check the hiring procedures that apply or are performed by this operation.

- Criminal Background Checks Reference Checks
 Questioning of employees in their previous involvement as defendants in professional malpractice litigation.
 Verification of certification or professional licensing.
 Drug, alcohol and sexual abuse screening or testing.

Schedule of Physicians – on Staff or Contracted:

Name & Specialty	Board Certified	Board Eligible	Hours/Week Worked	Volunteer Contracted or Employed	Has Malpractice Insurance
					<input type="checkbox"/> No <input type="checkbox"/> Yes
					<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you wish physician to be covered under the Center's policy?					<input type="checkbox"/> No <input type="checkbox"/> Yes
Are any drugs or medications administered or prescribed? If yes, explain.					<input type="checkbox"/> No <input type="checkbox"/> Yes
Is electroshock therapy utilized? If yes, how many per year?					<input type="checkbox"/> No <input type="checkbox"/> Yes

Schedule of Location: If more than 3 locations, attached a separate sheet of locations

#1 Address	
Type of Services Provided	
#2 Address	
Type of Services Provided	
#3 Address	
Type of Services Provided	

Services Provided:

Please indicate the Number of Beds

Mental Health Inpatient		Group Home	
Alcohol/Drug Inpatient		Shelters	
Alcohol/Drug Detox.		Independent Living	
Halfway House		Foster Care (children)	
Apartments		Other (specify)	

Please indicate the <i>Number of annual Outpatient or Client Visits</i>			
Alcohol/Drug Rehab		Counseling	
Mental Health		Methadone	
Please indicate the <i>Number of Clients per day</i>			
Adult Day Care		Partial Hospitalization	
Child Day Care		Sheltered Workshops	
Please indicate the <i>Number of Calls (annually)</i>			
Hotline		Information	
Transport – Emergency		Non-emergency	
Referral		Other (specify):	
Please indicate the <i>Annual Employee Assistance Programs (EAP) contracts or visits</i>			
Assessments		Counseling Visits	
Referrals		# of co.'s under contract	
Please indicate the <i>Number of Home Health Care Visits</i>			
Nonprofessional hours		IV Therapy	
Professional hours		Other (specify):	
Are there any camp, adventure/wilderness, ropes courses or any type of recreational programs? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe and submit brochure or detailed narrative of activities.			
Are there any swimming or boating activities? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Is pool fenced with a self-locking gate? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Diving board? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Slide? <input type="checkbox"/> No <input type="checkbox"/> Yes			

<input type="checkbox"/> Residential or Inpatient - <i>complete supplemental application</i>
<input type="checkbox"/> Foster Care or Adoption - <i>complete supplemental application</i>

Check the coverages and limits that the applicant would like quoted.			
What coverages:	<input type="checkbox"/> GL	<input type="checkbox"/> Professional	<input type="checkbox"/> Property (attach acord app)
Limits requested:	<input type="checkbox"/> 100/100	<input type="checkbox"/> 300/300	<input type="checkbox"/> 500/500
	<input type="checkbox"/> 1/1	<input type="checkbox"/> 1/2	<input type="checkbox"/> 1/3
Do you want physical abuse/sexual molestation coverage to protect you for alleged acts of your employees? <input type="checkbox"/> No <input type="checkbox"/> Yes			
At what limits:	<input type="checkbox"/> 25/50	<input type="checkbox"/> 50/100	<input type="checkbox"/> 100/300
	<input type="checkbox"/> 250/250	<input type="checkbox"/> 500/500	<input type="checkbox"/> Other
<i>Higher Abuse limits may be available for select risks.</i>			

Applicant's signature _____

Title _____

Date _____