AMC Professional Liability Insurance Application *for* Membership

Contact Data

Full Name (First, Middle, Last) ______ Practice / Clinic Name ______

Office or Mailing Address (Include Suite #) ______ City ______ State ______ Zip ______

Office Phone ______ Alternate Phone (Home, Cell, etc.) ______ Fax ______ Email ______

Massage License / Certification # ______ Issued By: ☐ State ☐ City ______ Date Issued ______ Massage School Attended ______ Date Graduated ______ Hours of Training ______

Professional Information

1. Do you hold a current Massage license / certification as required in the state where you practice? (If *YES*, attach copy) ☐ Yes ☐ No
2. Has any malpractice allegation ever been asserted against you or your associates, or has there been any event or indication suggesting a claim may be made or that your care might have been deficient or caused harm? (If *YES*, explain) ☐ Yes ☐ No
3. Has any board, agency, association, or insurer investigated or taken any action involving you or your license? (If *YES*, explain) ☐ Yes ☐ No
4. Have you ever had liability insurance refused, declined, canceled, or accepted on special terms? (If *YES*, explain) ☐ Yes ☐ No
5. Have you ever used any drug or substance that interfered with your ability to perform Massage duties? (If *YES*, explain) ☐ Yes ☐ No
6. Have you ever been charged with or convicted of any violation of the law other than a minor traffic offense? (If *YES*, explain) ☐ Yes ☐ No
7. Do you: do colonic irrigations, treat cancer, epilepsy, practice obstetrics, or make a differential diagnosis? (If *YES*, explain) ☐ Yes ☐ No
8. Have you ever provided Massage services to a professional athlete? (If *YES*, explain) ☐ Yes ☐ No
9. Are you providing any Massage service that was not a part of your massage school training program? (If *YES*, explain) ☐ Yes ☐ No
10. Do you hold any other health designation (RN, L.Ac, etc.) ☐ Yes ☐ No If *YES*, list here: ______ (Separate coverage is required)
11. Who provides your current Massage malpractice coverage? ______ Policy Expires: ______
12. List any entity you want as an additional insured *($10 / entity)*: ______
13. Your Massage insurance, if approved, will be effective the date your app. is received. For a later date, specify here: ______

Payment

Membership and Coverage		$99.00
Additional Insured	@ $10.00	
General Liability	@ $50.00	
Business Personal Property ($10,000 Limit – Lloyd's of London Policy – Incl. Tax)	@ $103.25	
Total Payment Remitted		

Pmt. Type: ☐ Check ☐ MasterCard ☐ Visa ☐ AMEX

Card #: ______ Exp: ______

Fax or Mail Completed Application To:

American Massage Council
1100 W. Town & Country Rd., Ste. 1400
Orange, CA 92868
800-500-3930 Phone 714-571-1863 Fax

Agreement & Signature

$1,000,000 / $3,000,000 Professional Liability Coverage

NO FALSE STATEMENTS: I hereby declare that the above statements are true, and I have not misstated or suppressed any facts. I agree and understand that my policy is issued in reliance upon such statements, that such statements are deemed material, that untrue statements could void my insurance and that this declaration shall be a basis of, and form a part of, my policy.

CLAIMS-MADE ONLY: I understand that if coverage is granted, the policy will only cover claims made during the policy period arising out of the rendering or of failure to render professional services subsequent to the retroactive date. I understand that if the policy terminates for any reason, there is no coverage for claims reported after the termination date (even though the injury occurred while the policy was in force), unless Extended Coverage is purchased within 30 days after termination.

RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS: I understand that there is no guarantee that coverage will be renewed. I understand that, if coverage is granted, I shall have the duty to report in writing, within 48 hours, or as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written patient complaints, or threats or filings of lawsuits.

SIGN: ______ **DATE:** ______

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