



# Membership Application

**Please complete the following:**

First Name		Middle Name		Last Name	
Clinic Name			E-Mail Address		
Office Address (Include Suite #)			Mailing Address (Include Suite #)		
City	State	Zip	City	State	Zip
Office Telephone		Fax		Home Telephone	

License Number(s) \_\_\_\_\_ State(s) Issued \_\_\_\_\_ Date(s) Issued \_\_\_\_\_ Social Security Number \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex  M  F

Acupuncture College or University \_\_\_\_\_ City, State, Country \_\_\_\_\_ Year of Graduation \_\_\_\_\_

**Professional Information:**

1. Has any suit, arbitration, or other claim or proceeding been brought against you, your acupuncture practice, associates, or employees for alleged malpractice? (If yes, explain on separate sheet.)  Yes  No
2. Do you know of any circumstances that would give rise to a claim being brought against you, your acupuncture practice, associates, or employees for professional malpractice? (If yes, explain on separate sheet.)  Yes  No
3. Has any government agency investigated, suspended, revoked, or taken any other action against your license to practice? (If yes, explain on separate sheet.)  Yes  No
4. Have you ever had professional liability insurance refused, declined, canceled or accepted on special terms? (If yes, explain on separate sheet.)  Yes  No
5. Have you used any intoxicant, narcotic, or other psychoactive drugs to the extent that it has interfered with your ability to perform professional duties; or used any illegal drug in the past year? (If yes, explain on separate sheet.)  Yes  No
6. Have you been convicted for an act committed in violation of any law or ordinance other than a minor traffic offense? (If yes, explain on separate sheet.)  Yes  No
7. Has any professional association suspended, revoked, or taken any other adverse action against you or your membership in any such association? (If yes, explain on separate sheet.)  Yes  No
8. Do you treat cancer or epilepsy? (If yes, explain on separate sheet.)  Yes  No
9. Do you ever charge or collect your fees per case, lump sum agreed on or paid in advance, or on contract with a patient for a pre-agreed sum? (If yes, explain on separate sheet.)  Yes  No
10. Do you ever use a collection agency to collect unpaid sums from patients?  Yes  No  
If yes, is your collection agency authorized to file suit to collect?  Yes  No
11. Have you (or has a collection agency on your behalf) filed suit to collect unpaid sums from patients? (If yes, explain on separate sheet.)  Yes  No
12. Have you ever treated a person that had previously been a research subject in any research program in which you were involved? (If yes, explain on separate sheet.)  Yes  No
13. Is anesthesia (other than topical or by means of local infiltration) been administered by either yourself or others? (If yes, explain on separate sheet.)  Yes  No
14. Do you prescribe or dispense any prescription drugs? (If yes, explain on separate sheet.)  Yes  No
15. Do you treat Medi-Cal or Medicaid patients? If Yes, what % of your practice is Medi-Cal/Medicaid? \_\_\_\_\_%  Yes  No

## Membership Application

16. Do you use any technique or therapy that is not currently taught in the acupuncture schools and colleges?  Yes  No  
 If Yes, please list: \_\_\_\_\_
17. Do you make a differential diagnosis?  Yes  No *If No, do you limit your responsibility to treating symptoms?*  Yes  No
18. Is your acupuncture license current?  Yes  No
19. Do you always maintain the needle shaft in a sterile state prior to insertion? (For example, after removing a disposable needle from packaging or removing a reusable needle from a sterile needle tray.)  Yes  No
20. Do you only use disposable needles?  Yes  No, I use some (or all) reusable.
21. Are your needles approved by the Food and Drug Administration?  Yes  No
22. Do you follow state guidelines for the sterilization of needles?  Yes  No  N/A - I only use disposable.
23. If you use disposable needles, do you use them for only one insertion on one patient during a single visit and then throw them away?  Yes  No  N/A - I only use reusable.
24. Do you always record the patient's account of his or her progress?  Yes  No  No, but I will do so.
25. Do you always record objective findings?  Yes  No  No, but I will do so.
26. Do you always record details of treatment procedures?  Yes  No  No, but I will do so.
27. Do you always require your patients to sign an informed consent? (If yes, attach a copy of the form you use.)  Yes  No  No, but I will do so.
28. Which best describes your practice structure:  Sole Proprietor  Professional Corp.  Partnership  Employee  Contractor  
 List names of Entity, Partners, and/or Employers \_\_\_\_\_
29. Do you wish coverage for your corporation, partnership or any other entity or person? (An additional charge applies.)  Yes  No  
 If Yes, please print name(s): \_\_\_\_\_
30. Are you licensed to practice any other health care profession?  Yes  No  
 If Yes, please circle: MD, DO, DPM, DC, RN, RPT, Other \_\_\_\_\_  
 If Yes, name malpractice insurance company for other profession \_\_\_\_\_ Policy expires \_\_\_\_\_
31. Do you now have acupuncture professional liability insurance?  Yes  No  
 If Yes, name malpractice insurance company \_\_\_\_\_ Policy expires \_\_\_\_\_
32. What date would you like for your insurance to be in effect (may not be before the date your application is received)? \_\_\_\_\_
33. Do you refer to other doctors or health care practitioners?  Yes  No  
 If Yes, please circle: MD, Ortho, Neuro, GP, DC, RN, RPT, Other: \_\_\_\_\_
34. Provide the names of any health care practitioners with whom you work, or share office/reception space, personnel, equipment or letterhead (including acupuncturists, medical doctors, doctors of osteopathy, doctors of chiropractic, podiatrists, nurses, anesthetists, physical therapists, student or graduate preceptees, etc.): Include name and practice type (L.Ac., MD, DO, DC DPM, RN, PT).  
 \_\_\_\_\_  
 \_\_\_\_\_
35. Approximate number of patients you see weekly: \_\_\_\_\_
36. How many hours per week do you spend in direct professional work with patients? \_\_\_\_\_
37. What is the average time you spend professionally with each patient on a first office visit? \_\_\_\_\_ Follow up visit? \_\_\_\_\_
38. Please list all honors, recognition, awards, or publications of a professional nature. \_\_\_\_\_  
 \_\_\_\_\_
39. List all hospitals at which you have ever held staff membership or at which you completed a residency and describe briefly the extent and dates of your hospital privileges, and, if applicable, the circumstances under which such privileges were suspended or terminated.

Name of Hospital	Address	City	State	Country	Dates of Affiliation

## Membership Application

40. Please list all current memberships in acupuncture related specialty boards, academics, or colleges and dates so certified.

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41. List all acupuncture teaching appointments you have held.

Name of School	Address	City	State	Country	Dates Held
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42. State pre-acupuncture education. Use a separate sheet if necessary.

College or University	Address	City	State	Country	Dates Attended
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Degree	Major	Year of Graduation
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**Signatures:** *(Signatures are required in four places.)*

**RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS:** I understand that there is no guarantee that coverage will be renewed. I also understand that any price distinctions based on safe acupuncture practices may be based in part on information provided by me on future follow-up data sheets or during future pre-arranged office inspections. I understand that, if coverage is granted, I shall have the duty to report in writing, within 48 hrs., 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: \_\_\_\_\_

**CLAIMS-MADE ONLY:** *(Does not apply if your Claims Reporting Basis is "Occurrences")* I understand that if a policy of insurance is issued based on the statements in this application, except as otherwise provided in that policy, the policy is limited to claims made against the Insured during the policy period arising out of the rendering or failure to render professional services subsequent to the retroactive date. I understand that if the policy terminates due to nonpayment of premium or cancellation by the Insured or Insurer, there is no coverage for claims reported after the termination date (even though the injury occurred while the policy was in force) unless the Insured purchased an Extended Coverage Policy within 30 days after termination.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

**NO FALSE STATEMENTS:** I hereby declare that the above statements are true and that I have not suppressed or misstated any facts and I agree that this declaration shall be a basis of the contract and form a part of my acupuncture professional liability insurance policy. I understand that untrue statements could void my insurance policy.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

**RELEASE OF INFORMATION:** I hereby authorize release and exchange of information from: My professional acupuncture associations, organizations, societies, any hospitals I presently or previously held staff privileges with, insurance carriers, trusts, administrators, etc., in past and future underwriting and claims matters, State Board of Acupuncture Examiners, and credit agencies to: the American Acupuncture Council or an investigator employed by the American Acupuncture Council. I further agree that the organization releasing or obtaining the information, its agents, servants and employees, shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I agree that a photocopy of this Release of Information form will be as valid as the original.

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

**Payment Information:** *(Complete information below, as well as Professional Information and Signatures on pages 1, 2 and 3)*

<p><b>Mail or Fax Completed Application to:</b></p> <div style="text-align: center;"> <p><b>Schlitt Insurance Services</b>                  1717 Indian River Blvd., #300                  Vero Beach, FL 32960                  (Fax) 772-778-1416 (Phone) 800-736-3448</p> </div>	<p><b>Payment Information:</b></p> <p>Installment Due (See Page 5): _____</p> <p>_____</p> <p><b>Total Amount Remitted:</b> _____</p> <p>If paying by Credit Card, complete the following:</p> <p>Card # _____ Expires _____</p> <p>You are hereby authorized to charge this card for the amount above to activate my AAC coverage. I agree to pay this amount according to the terms of the card issuer agreement.</p> <p>Signature _____</p>
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See "Choose Your AAC Coverage Option" to Select a Limit and Rate

SUPPLEMENT TO APPLICATION FOR ACUPUNCTURIST'S MALPRACTICE

PRACTITIONER'S NAME: \_\_\_\_\_

Selection of Coverage Limit:	<u>ANNUAL</u>	<u>QUARTERLY</u>
_____ \$500,000 Occurrence/\$500,000 Aggregate	\$750	\$201
Licensed 12 months or less	\$375	\$ 98
Licensed 12-24 months	\$540	\$143
_____ \$1,000,000 Occurrence/\$1,000,000 Aggregate	\$850	\$229
Licensed 12 months or less	\$425	\$112
Licensed 12-24 months	\$620	\$166
_____ \$1,000,000 Occurrence/\$3,000,000 Aggregate	\$900	\$243
Licensed 12 months or less	\$450	\$119
Licensed 12-24 months	\$660	\$177

**You may qualify for a discounted rate if you are a 1<sup>st</sup> year graduate or member of an association such as the FSOMA, APA, or FAA. Call for rates.**

\_\_\_\_\_ I wish to have "Entity Coverage" for the partnership or corporation named in question #28, and have included 10% of the above indicated as additional premium for each additional insured. In addition, I have answered yes to the "corporate coverage" portion of question #29.

***FLORIDA FRAUD STATEMENT***

*Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.*

I have selected the above limit and coverage option and have enclosed full payment of the premium payable to "Schlitt Insurance Services, Inc.". I certify that I am a graduate of the Atlantic Institute of Oriental Medicine, Inc.

I understand that coverage will take effect the date after receipt – if the application is completely filled out & acceptable by the underwriter.

Signed \_\_\_\_\_ Date \_\_\_\_\_

**RETURN SUPPLEMENT ALONG WITH APPLICATION & TOTAL PREMIUM TO:**

SCHLITT INSURANCE SERVICES, INC.  
1717 INDIAN RIVER BLVD., #300  
VERO BEACH, FL 32960