



COUNSELORS/SOCIAL WORKERS PROFESSIONAL LIABILITY APPLICATION

1. Applicant's Name _____ Effective Date: _____

2. Address _____ RETRO DATE* : _____

Type of Operation: _____

3. Limits of Liability: Each Wrongful Act/Aggregate: \$ _____ /\$ _____.

4. Agency is licensed or certified by _____

5. Do you currently comply with any state or municipal licensing requirements in the operation of your facility? Yes No No Licensing Required If yes, describe. If no, state reasons for non-compliance and steps being taken to correct this. _____

6. Is the facility a member of any professional association or organization? Yes No
If no, please explain. _____

Name of accrediting body _____

7. Is the facility accredited by any governmental entity or other body? Yes No
If no, please explain. _____

Name of accrediting body _____

8. Has any outside body (accrediting or governmental, insurance company, etc.) conducted an inspection of your facility within the last three (3) years? Yes No If yes, name of inspecting body and type of inspection conducted (i.e., physical plant, protocols, etc.):

Name	Type
_____	_____
_____	_____

* If Retro Date is other than Effective Date, completed Prior Acts Application/Statement is required.

9.	List number of:	Staff	Volunteers	Independent Contractors
	A. RNs/LPNs	_____	_____	_____
	B. MDs	_____	_____	_____
	C. Psychiatrists	_____	_____	_____
	D. Psychologists	_____	_____	_____
	E. Social Workers	_____	_____	_____
	F. Therapists-Physical, Speech, Hearing	_____	_____	_____
	G. Other Professionals	_____	_____	_____
	List: _____			
	H. Remaining Staff	_____	_____	_____

10. Is there a pre-employment background check for all employees/volunteers/independent contractors?
 Yes No If yes, in writing by phone.

11. Mark those items included in the pre-employment check
- Personal References
 - Law Enforcement Agencies Check
 - Educational Verification

12. List the name, degree, field of study, and professional association of which each professional is a member:

Attach Separate List If Necessary

Name	Degree	Field of Study	Registered Member of...

13. Agency is Member of...

- Child Welfare League of America
- Family Service Association of America
- United Way
- Other _____

14. Any Contractual Agreements in place? Yes No If yes, explain _____

15. Check the following which apply to your Agency
- Foster Care Child Placement Adoption Residential Home
 - Other (describe) _____

16. Total number of visits annually

Visits = The number of patients entering your facility for health-related services, regardless of the number of departments visited or the number of procedures/treatments performed within each department.

- | | | |
|---------------------------------------------|----------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Mental Health Center | <input type="checkbox"/> Physical/Occupation Rehab Center |
| <input type="checkbox"/> Abortion Clinic | <input type="checkbox"/> Drug Alcohol Rehab Center | <input type="checkbox"/> Weight Loss Center |
| <input type="checkbox"/> Dialysis Center | <input type="checkbox"/> Visiting Nurse Assoc. | <input type="checkbox"/> Urgicenter (Walk-in clinic) |
| <input type="checkbox"/> Surgicenter | <input type="checkbox"/> Blood/Plasma Bank | <input type="checkbox"/> Emergicenter (Freestanding ER) |
| <input type="checkbox"/> Birthing Center | <input type="checkbox"/> Student Health Center | <input type="checkbox"/> Community Health Center |
| <input type="checkbox"/> Home Health Agency | <input type="checkbox"/> Cardiac Rehab Center | <input type="checkbox"/> Other _____ |

17. Agency is funded by _____

18. Has the Agency or any or its employees ever been reprimanded by, or refused admission, or suspended before any court, association, or administration agency? Yes No If yes, explain in detail _____

19. Do any employees dispense medication? Yes No If yes, describe _____

20. Describe medical record keeping system _____

21. Is the agency aware of any circumstances which may result in any claim being made against the agency, its predecessors in business, or any of its present/past officers or employees? Yes No
If yes, explain in detail _____

22. Have any claims or suits been made during the past five (5) years against the agency, its officers or any of its employees, or to the knowledge of the agency, against any past employees? Yes No
If yes, explain in detail _____

23. Has any similar insurance for the agency, present officers, or employees ever been canceled?
 Yes No If yes, explain _____

24. Has there ever been incident(s) of physical or sexual abuse arising in connection with your premises or operations? Yes No If yes, explain in detail _____

25. Has there ever been any investigation of your operations by any public authority relating to sexual or physical abuse? Yes No If yes, explain in detail _____

26. Prior Insurance Carrier _____

I HEREBY DECLARE TO THE BEST OF MY KNOWLEDGE AND BELIEF THAT ALL OF THE FOREGOING STATEMENTS ARE COMPLETE AND TRUE, AND THAT THESE STATEMENTS ARE OFFERED AS AN INDUCEMENT TO THE POOL TO ISSUE THE POLICY FOR WHICH I AM APPLYING. IT IS UNDERSTOOD AND AGREED THAT THE COMPLETION OF THIS APPLICATION DOES NOT BIND THE POOL.

Applicant Signature

Date

Title: _____