



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 _____
Is license current? _____ Special certifications, if any: _____

5. Do you currently comply with state and/or municipal licensing requirements in the operation of your facility? Yes No Licensing Not Required. If yes, describe. If no, state reasons for non-compliance and steps being taken to correct. _____

6. Is the facility a member of any professional association or organization? Yes No
Name of assoc / org.: _____
If no, explain: _____

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

8. Has any outside body (accrediting or governmental, insurance company, etc.) inspected 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
_____	_____
_____	_____

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

*** If the Retro Date is other than Effective Date, a Prior Acts Application/Statement is required**

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

11. If applicant uses Independent Contractors (IC), including Registry Providers: does applicant verify all ICs carry the same insurance coverage, terms & limits the Applicant is required to carry by contract, and are Certificates of Insurance obtained from the IC provider when contracted by Applicant and annually thereafter?
 yes _____ No _____ **If No, applicant does not qualify for the SSCIP Program**

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

13. Mark those items included in the pre-employment check:
 Personal References Educational Verification Law Enforcement Agencies Check
 If applicable, appropriate Licensing with no violations

14. List the following information & professional association for each Professional:
Attach Separate List If Necessary

Name	Degree	Field of Study	Registered Member of...

15. Agency is Member of: United Way Child Welfare League of America
 Family Service Association of America Other _____

16. Agreements you have with State or Local Agencies: _____

17. Your Agency is funded by: _____

18. Total number of clients, meaning *the number of clients serviced annually, regardless of the number of departments visited or the number of procedures / treatments performed within each department*: _____.
19. Has the Agency or any of its employees ever been reprimanded by, or refused admission, or suspended by any court, association, or administration agency? Yes No If yes, explain in detail: _____

20. Do any employees dispense medication? Yes No If yes, describe _____
21. Describe medical record keeping system _____

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

23. 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: _____

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

26. 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 _____

27. Prior Insurance Carrier _____

I HEREBY DECLARE TO THE BEST OF MY KNOWLEDGE AND BELIEF THAT ALL 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: _____