COUNSELORS/SOCIAL WORKERS
PROFESSIONAL LIABILITY APPLICATION

1. Applicant's Name _____ Effective Date: _____

2. Address _____ **RETRO DATE*** : _____

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

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 ☐ 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
Name of assoc./org: _____
If no, please explain. _____

7. Is the facility accredited by any governmental entity or other body? ☐ Yes ☐ No
Name of assoc./org.: _____
If no, please 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
☐ Outpatient Facility (describe services offered):_____
☐ Other (describe): _____

10. List number of:

		Employees		Volunteers		Independent Contractors		Registry	
		FT	**PT**	**FT**	**PT**	**FT**	**PT**	**FT**	**PT**
A.	RNs/LPNs								
B.	MDs								
C.	Psychiatrists								
D.	Dentists								
E.	Psychologists								
F.	Physician's Assistants								
G.	Social Workers								
H.	Licensed Nurse Practitioners								
I.	Therapists-Physical, Speech, Hearing								
J.	Other Professionals List: _____								
K.	Remaining Staff (Does not include admin/clerical)								

11. If Applicant uses Independent Contractors (IC) or Registry Providers (RP), does Applicant verify the IC and/or RP carry same coverage & limits Applicant is required to carry by contract, and are Certificates of Insurance obtained from the IC/RP when contracted by Applicant and annually thereafter?
☐ Yes ☐ No If No, please provide details. _____

12. Is a medical doctor on staff overseeing outpatient services? ☐ Yes ☐ No

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

14. Mark those items included in the pre-employment check

Personal References	☐	Law Enforcement Agencies Check	☐
Educational Verification	☐	If applicable, appropriate licensing with no violations	☐

15. Your Agency is funded by: _____

16. 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: _____

17. Is counseling / evaluations provided for sex offenders? ☐ Yes ☐ No
If yes, what % of your total number of clients are sex offenders? _____

18. Has the Agency or any of its employees ever been reprimanded by, refused admission, or suspended by 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: _____