SPORTS REHABILITATION PROGRAM APPLICATION

1. APPLICANT INFORMATION:

a) Name of Applicant/Entity(s)_____

_____

_____

b) Date of Incorporation/Start of Operations: _____

c) Physical Address (City, State, Zip Code) _____

_____

d) Hours of Operation _____

e) Are clientele given remote access or allowed to use equipment/treatments without a trained employee supervising the treatments? ◯ Yes ◯ No

If yes, please provide details.

f) Telephone_____Fax_____Website_____

g) Legal Structure: ◯ Individual ◯ Partnership ◯ LLC ◯ Corporation ◯ Joint Venture ◯ Other_____

h) Tax Status: ◯ For Profit ◯ Not for Profit ◯ Governmental ◯ Other_____

i) List names, location, and descriptions of all legal entities, including subsidiaries for which Applicant is a part (continue a separate sheet if necessary)

Loc #	Business Name and Address	Description	Date Acquired	Ownership%	Retroactive Date

j) Have you sold, discontinued, or acquired any operations in the past 5 years, or do you plan to in the upcoming year? (Please list including name of entity and date acquired) ◯ Yes ◯ No

_____

_____

k) List all licenses held by your facility including type and expiration dates.

_____

l) List any/all accreditation from governmental agencies/clients (JCAHO, AABB, AATB, FACT, ABC, CLIA, AOPO, EBAA, CAP, ASHI, etc.) and association memberships held by your facility and include a copy of your most recent report.

_____

_____

2. Email _____

3. Facebook, Instagram, Twitter and other social media addresses/usernames _____

_____

4. Limits Desired - Retention GL? _____

5. Current Insurance Services: Revenues OPVs

a. Physical Therapy _____ _____
b. Fitness Coaching _____ _____
c. Acupressure _____ _____
d. Acupuncture _____ _____
e. Dry Needling _____ _____
f. Massage Therapy _____ _____
g. Aquatic Therapy
   i. Pool? _____ _____
   ii. Tanks? _____ _____
h. Stem Cell Therapy _____ _____
i. IV therapy _____ _____
j. Occupational Therapy _____ _____
k. Nutritional Counseling _____ _____
l. Dietician _____ _____
m. Surgery – outpatient
   i. With Local Anesthetic _____ _____
   ii. With General Anesthetic _____ _____
n. Surgery – in patient _____ _____
o. InfraRed Sauna _____ _____
p. Platelet Rich Plasma Injections _____ _____
q. Kinseotaping _____ _____
r. Others _____ _____
s. Lasers _____ _____
   i. Cold _____ _____
   ii. Class IV Warm/Hot _____ _____

6. If Class IV lasers are used, please answer the following additional questions:

   a. How many technicians are operating the lasers? _____
   b. How many hours training do they have? ◯ Yes ◯ No
   c. Do all technicians have at least 6 months experience? ◯ Yes ◯ No
   d. Are lasers operated in a room with absolutely no reflective surfaces? ◯ Yes ◯ No
   e. Are doors locked during treatments and is there a sign posted that states "lasers are in use, do not enter"? ◯ Yes ◯ No
   f. Are eye goggles worn by both technician and patient/client the entire time of treatment? ◯ Yes ◯ No
   g. Are all state laws followed as to need for Medical Director/Physician Consultant on staff? ◯ Yes ◯ No

7. Product sales $_____
   a. Please describe products _____
      _____
   b. Do you manufacture any products? _____
   c. Do you private label any products? _____
   d. Please provide labels for all products sold or link to website of manufacturer where ingredients lists can be found. _____
   e. Does the manufacturer/distributor provide you with vendors additional insured coverage? _____

8. If Surgeries performed- please list all procedures: _____
9. Are any procedures considered spinal procedures? _____
10. How many surgical procedures are performed under general anesthesia? _____
    Local anesthesia? _____
11.
    a) Does the insured have any beds for overnight stays?..... ☐ Yes ☐ No
    (if yes, number of beds and average occupancy)
    _____

    b) Has your facility been surveyed by an accreditation agency within the past three years?
    ☐ Yes ☐ No
    i. If "Yes", please list date(s) of last survey: _____

    c) Does the insured provide any services outside of the United States?..... ☐ Yes ☐ No
    (if yes, Please explain)
    _____

    d) Do you compound in bulk, manufacture, or wholesale medicine?..... ☐ Yes ☐ No
    (if yes, Please explain)
    _____

    e) Does the applicant anticipate making any significant changes in the services/products provided within the next 12 months?..... ☐ Yes ☐ No
    (if yes, please explain)
    _____

12. Treatment of Minors?_____What %?_____What procedures? _____
    _____

13. Licensed/Professional staff – including Physicians, Surgeons, Podiatrist, Chiropractors, Physical Therapists, Occupational Therapists, RNs, LPNs, EMTs, etc.

Name	Specialty	Board Certified	Hours Worked	Volunteer, Contracted or Employed	Has own Malpractice Insurance	Medical Director
		☐ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No	☐ Yes ☐ No

i. Is physician credentialing and privileging formalized and documented? ☐ Yes ☐ No
ii. Do any of the above physicians have direct patient care responsibilities? ☐ Yes ☐ No
(if Yes, what is the physician's role in providing services for the applicant's facility?)

_____

_____

14. Please provide details of all other staff utilized.

Health Professional	Has Own Professional Liability Coverage?	Employed			Contracted		
		Full Time	Part Time	Hours	Full Time	Part Time	Hours
Registered Nurses							
Licensed Practical Nurses							
Licensed Vocational Nurses							
Nurse Practitioners							
Physician Assistants							
Certified Nursing Assistants							
Physical, Occupational, and Speech Therapists							
Home Health Aides							
Sitters/Companions							
Emergency Medical Technicians							
Paramedics							
Pharmacists							
Technicians							
Social Workers							
Other (please provide description)							

15. RISK MANAGEMENT, CLAIMS HANDLING & LOSS CONTROL

a. Does the applicant have a full-time risk manager on staff?..... ☐ Yes ☐ No
(if yes, please provide the following details.)
Name_____
Title_____
Telephone (_____)_____
Qualifications/Experience_____

b. Does the applicant have a formal, written risk management/loss prevention program?
(Please provide details, separately if necessary) ..... ☐ Yes ☐ No

c. Does the applicant require new employees to participate in a training program that instructs them on all applicable company policies and procedures?..... ☐ Yes ☐ No

d. Does the applicant handle claims in-house or utilise the services of a third party administrator?
(Please provide details of in-house claims personnel/TPA used)
_____

16. CREDENTIALING:

a. Are all health professionals credentialed prior to hiring?..... ☐ Yes ☐ No

b. Are physicians required to be board certified in their specialty?..... ☐ Yes ☐ No

c. How often are physicians re-credentialed? _____

d. Prior to hiring any employee, does the applicant verify:
i) Education background and training?..... ☐ Yes ☐ No
ii) Employment references with at least two previous employers?..... ☐ Yes ☐ No
Criminal record, on a Local, State and National scale? (Please indicate which apply)
_____
iii) Driving record?..... ☐ Yes ☐ No
Credit record?..... ☐ Yes ☐ No
iv) Drug tests?..... ☐ Yes ☐ No
v) Sex Offender Registry?..... ☐ Yes ☐ No

e. Does the applicant keep all information on file and verify its completion prior to employment commencement?..... ☐ Yes ☐ No

17. COVERAGE HISTORY:

a. Please provide details of professional liability coverage purchased in the last five (5) years to date:

Policy Period	Primary/Xs Limit	SIR/Deductible	Carrier	Annual Premium	Occurrence Or Claims Made?	Retroactive Date

b. Please provide details of general liability coverage purchased in the last five (5) years to date:

Policy Period	Primary/Xs Limit	SIR/Deductible	Carrier	Annual Premium	Occurrence Or Claims Made?	Retroactive Date

c. Do you currently carry employee benefits liability coverage?..... ☐ Yes ☐ No
If yes, what is the employee count, limit, deductible, and retroactive date?

_____

d. Has the applicant ever been declined or refused coverage, or had its coverage cancelled or non-renewed?..... ☐ Yes ☐ No
If yes, please explain.

_____

18. Are you aware of, advertise for or otherwise promote services to professional/Collegiate athletes, celebrity of other high profile clients?..... ☐ Yes ☐ No
If Yes, please give.
a. Associated revenues: $_____Annual treatments: _____
b. Type of Athletes (i.e pro/collegiate football, MMA, actor/actress politician, etc.) _____
_____
c. List these clients by name (if more space is needed please attach a separate list and note 'see attached' below) : _____

_____

_____

_____

_____

19. Have you in the past, or do you plan to begin in the future, provide or offer services to anyone under the age of 18 ? ◯ Yes ◯ No

If Yes, please provide a breakdown of the age of minors treated by percent (must total 100% of minor services):

- Under 5 years old _____%
- 5 years – 9 years old _____%
- 10 years -13 years old _____%
- 14 years – 18 years old _____%

a. Please state the average number of monthly visits for clients under 18
b. Are employees in the same room as clients under 18 when they are undressing? ◯ Yes ◯ No
c. Are there cameras in the treatment rooms? ◯ Yes ◯ No
d. Do parents always remain present with minors under 14 during treatment? ◯ Yes ◯ No
e. Does the insured follow all manufacturer's guidelines for all machines, modalities, treatments and services, including but not limited to any age restrictions? ◯ Yes ◯ No
f. Does the insured require an expanded waiver, signed by the parent/guardian that lists any additional risks of treatments based on age? ◯ Yes ◯ No
g. What specific services, modalities, and treatments are minors under the age of 14 allowed to receive? Please list all services for minors under 14 _____

20. INSURED HISTORY – CLAIMS, LOSSES, AND INCIDENTS:

a. Has any claim or suit for an error, omission or malpractice ever been made against you or your organization or any employees/staff working on your behalf?..... ☐ Yes ☐ No
If Yes, how many?_____Complete a copy of Supplemental Claim form for each.

b. Are you or any proposed insured for this insurance aware of any claim or suit, or any act, error, omission, fact, circumstance, or records request from any attorney which may result in a malpractice, general liability, or products liability claim or suit?..... ☐ Yes ☐ No
If Yes, has each of these been reported to the current or any claim or suit?..... ☐ Yes ☐ No
How many?_____Complete a copy of Supplemental Claim form for each.

c. Has the applicant or any staff:

i. ever been the subject of disciplinary/investigative proceedings or reprimand by governmental/administrative agency, hospital or professional association? ☐ Yes ☐ No

ii. ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses?..... ☐ Yes ☐ No

iii. ever been treated for alcoholism or drug addiction?..... ☐ Yes ☐ No

iv. ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refuses or accepted only on special terms or ever voluntarily surrendered same?..... ☐ Yes ☐ No
(if yes, please provide an explanation on any/all incidents)

THE UNDERSIGNED IS AUTHORIZED BY THE APPLICANT AND DECLARES THAT THE STATEMENTS SET FORTH HEREIN AND ALL WRITTEN STATEMENTS AND MATERIALS FURINSHED TO THE INSURER IN CONJUNCTION WITH THIS APPLICATION ARE TRUE. SIGNING OF THIS APPLICATION DOES NOT BIND THE APPLICANT OR THE INSURER TO COMPLETE THE INSURANCE, BUT IT IS AGREED THAT THE STATEMENTS CONTAINED IN THIS APPLICATION, ANY SUPPLEMENTAL ATTACHMENTS, AND THE MATERIALS SUBMITTED HEREWITH ARE THE BASIS OF THE CONTRACT SHOULD A POLICY BE ISSUED AND HAVE BEEN RELIED UPON BY THE INSURER IN ISSUING ANY POLICY.

THIS APPLICATION AND MATERIALS SUBMITTED WITH IT SHALL BE RETAINED ON FILE WITH THE INSURER AND SHALL BE DEEMED ATTACHED TO AND BECOME PART OF THE POLICY IF ISSUED. THE INSURER IS AUTHORIZED TO MAKE ANY INVESTIGATION AND INQUIRY IN CONNECTION WITH THIS APPLICATION AS IT DEEMS NECESSARY.

THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, THE APPLICANT WILL, IN ORDER FOR THE INFORMATION TO BE ACCURATE ON THE EFFECTIVE DATE OF THE INSURANCE, IMMEDIATELY NOTIFY THE INSURER OF SUCH CHANGES, AND THE INSURER MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS OR AUTHORIZATIONS OR AGREEMENTS TO BIND THE INSURANCE

I HAVE READ THE FOREGOING APPLICATION OF INSURANCE AND REPRESENT THAT THE RESPONSES PROVIDED ON BEHALF OF THE APPLICANT ARE TRUE AND CORRECT.

FRAUD WARNING DISCLOSURE

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT (S)HE IS FACILITATING A FRAUD AGAINST THE INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO ALABAMA, ARKANSAS, LOUISIANA, NEW MEXICO AND RHODE ISLAND APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD

THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: 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.

NOTICE TO KANSAS APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY FOR PERSONAL OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO; OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT.

NOTICE TO MAINE, TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO OKLAHOMA APPLICANTS: WARNING**:** ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO KENTUCKY, NEW JERSEY, NEW YORK, OHIO AND PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIMS CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES. (IN NEW YORK, THE CIVIL PENALTY IS NOT TO EXCEED FIVE THOUSAND DOLLARS ($5,000) AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.)

Signed:_____

Date:_____

Print Name: _____

Title: _____
(Owner, Partner, Authorized Officer)

If this **Application** is completed in Florida, please provide the Insurance Agent's name and license number. If this **Application** is completed in Iowa or New Hampshire, please provide the Insurance Agent's name and signature only.

Agent's Printed Name: _____

Florida Agent's License Number: _____

Agent's Signature: _____