

11. Are you currently insured? Yes No (If yes, please attach a current declarations page)
 If yes, name of Insurance Company: _____ Expiration Date: _____
 Current Retroactive Date: _____ Current Limits of Liability: _____
12. List any professional acupuncture association and/or society of which you are a member: _____
13. Acupuncture education:
 Name of school: _____ City, State: _____
 Date of graduation: ____/____/____
14. List all other healthcare providers practicing at each office location. Doctor's Name Specialty (i.e., L.Ac., D.C., M.D.), and the name of their insurance carrier

II . Your Practice

15. What acupuncture methods do you use?
 Needling Indirect Moxibustion Cupping Acupressure Electroacupuncture
 Direct Moxibustion - Is barrier used? Yes No Other: _____
16. Are all herbs prepackaged? Yes No
 If NO, what percentage of your practice uses NON-prepackaged herbs? _____%
17. Do you recommend, dispense or sell herbs to NON-Patients? Yes No
 If YES, a. What percent of your herb sales are to NON-patients? _____%
 b. Are you doing a diagnosis before dispensing herbs to NON -patients? Yes No
18. Do you practice acupuncture outside an office setting? Yes No
 If YES, please describe: _____
19. What is your average number of hours worked per week? _____
20. What is the average number of patients seen per week? _____
21. Average time you spend with a patient on a first visit? _____ Follow up visit _____
22. a. Do you allow needles to remain in the patient for more than 24 hours? Yes No
 b. Are needles used for more than one insertion? Yes No
 If YES to any of the above, please explain in Section III, Supplemental Answers
 c. Do you record the number of needles inserted and the number of needles withdrawn? Yes No
 If NO, please explain: _____
23. a. Are only disposable stainless steel needles used? Yes No
 b. Are needles disposed of after each use? Yes No
 c. Are impervious containers used for disposal of needles? Yes No
 d. Do you always use techniques which allow the needle shaft to remain sterile prior to insertion? Yes No
 If NO to any of the above, please explain in Section III, Supplemental Answers
24. a. Do you record histories of each patient before beginning treatment? Yes No
 b. Do you always record the patient's account of his/her progress? Yes No
 c. Do you always record objective findings? Yes No
 d. Do you always record details of treatment procedure? Yes No
 If NO to any of the above, please explain in Section III, Supplemental Answers.
25. Do you refer patients to other physicians or healthcare practitioners? Yes No
 If YES, please circle: DC Ortho MD Neuro GP DPM RPT
 Other: _____
26. Do you obtain the patient's written informed consent prior to treatment? Yes No
 If NO, please explain in Section III, Supplemental Answers

27. a. Have you ever had a claim made (verbal or written) or lawsuit filed against you? Yes No
- b. Are you aware of an incident that may result in a claim being made against you? Yes No
- If YES to any of the above, please provide a brief narrative, including reason for patient's visit, diagnosis, treatment given, allegations, and status of claim (open or closed). If closed, was it settled, dismissed or litigated? How much, if any, was paid?

28. Have you ever:
- a. had malpractice insurance declined, non-renewed for underwriting reasons, cancelled or issued on a restrictive basis? Yes No
- b. had any healthcare license subject to probation, revoked, suspended or had a complaint filed against you? Yes No
- c. been convicted of or pleaded no contest to a violation of any law or ordinance other than a minor traffic offense? Yes No
- d. had privileges at any hospital or other institution reduced, revoked, restricted or suspended? Yes No
- e. had any chronic illness, disability or drug- or alcohol-related condition that affected your ability to practice any healthcare profession? Yes No
- If YES to any of the above, please provide a brief narrative and attach supporting documentation.

29. Are you a faculty member of an Acupuncture college? Yes No
- If YES, name of college: _____
- How many hours do you work as a faculty member? _____

III. Supplemental Answers	

PLEASE READ CAREFULLY AND SIGN BELOW WHERE INDICATED

The undersigned declares that the statements set forth herein are true. The undersigned agrees that if the information supplied on this application changes between the date of this application and the effective date of the insurance, he/she (undersigned) will immediately notify the company of such changes, and the company may withdraw or modify any outstanding quotations, authorization or agreement to bind the insurance. Signing of this application does not bind the applicant or the company to complete the insurance, but it is agreed that this application shall be the basis of the contract should a policy be issued, and it will be attached to and become a part of the policy. All written statements and materials furnished to the company in conjunction with the application are hereby incorporated by reference into the application and made a part hereof. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, and is subject to criminal and civil penalties. Penalties may include imprisonment, fines, denial of insurance, and/or 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 settlement or award payable from insurance proceeds shall be reported to the state division of insurance within the department of regulatory agencies.

Applicant signature: _____ Date: _____

Print Name: _____

Claims Information

PLEASE MAKE COPIES OF THIS PAGE AS NEEDED

Note: Please provide sufficient information for underwriters to evaluate the aspects of the case, especially relating to your involvement.

- 1. Name of Patient _____ Age: _____ Male Female
- 2. Allegation _____

- 3. Date claim filed _____ Date of incident _____
Location of occurrence _____
- 4. Insurance company providing coverage _____
- 5. Additional defendants _____
- 6. Disposition of claim
 Open
 Closed Date closed _____ Total settlement or judgment _____
Amount paid on your behalf _____

The following questions should be answered in adequate clinical detail to allow proper evaluation. Please attach copies of the claimant's office and hospital records, laboratory reports and any other information that would be appropriate. Attach additional sheets as required.

- 7. Condition and diagnosis at time of incident (Include dates of visit)

- 8. Dates and description of treatment rendered (Include dates of visits)

- 9. Condition of patient subsequent to treatment (Include dates of follow-up treatment)

I understand that information submitted herein becomes part of the OUM Malpractice Insurance Application.

Signature

Date