



NATIONAL PHYSICAL THERAPY COUNCIL MEMBERSHIP APPLICATION



PROFESSIONAL LIABILITY COVERAGE LIMITS - \$1,000,000 PER OCCURRENCE / \$3,000,000 AGGREGATE

CONTACT AND PRACTICE INFORMATION

Full Name (First, Middle, Last)		Practice / Clinic Name	
Office Address (include Suite #)	City	State	Zip
Mailing Address – If Different from Office Address	City	State	Zip
Office Phone	Alternate Phone (Home, Cell, etc.)	Fax	Email
Physical Therapist License Number(s)	State Issued	Date Issued	Physical Therapy College and Location
			Year Graduated
Social Security Number	Birth Date	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	

FAX OR MAIL COMPLETED APPLICATION TO:



NATIONAL PHYSICAL THERAPY COUNCIL
1100 W. Town and Country Rd., Ste. 1400
Orange, CA 92868
P: 800-622-6869 F: 714-571-1863

PAYMENT DETAIL

Membership and Coverage	\$390.00
Optional Additional Insured (\$10/Entity)	_____
Optional Premises Liability (\$75/Location)	_____
TOTAL PAYMENT REMITTED	=====

CREDIT CARD PAYMENTS, COMPLETE FOLLOWING:

Card Type: Visa MasterCard American Express

Card #: _____

Expires: _____

You are hereby authorized to charge my credit card for the amount indicated above for coverage through the National Chiropractic Council. I agree to pay this amount according to the terms of the card issuer agreement.

SIGNATURE: _____

NATIONAL PHYSICAL THERAPY COUNCIL

Membership Application

PROFESSIONAL INFORMATION

1. Has any malpractice allegation ever been asserted against you or your associates, or has there been any event or indication suggesting a claim may be made or that your care might have been deficient or caused harm? (If YES, explain) Yes No
2. Has any agency or association investigated or taken any other action against you or your certification? (If YES, explain) Yes No
3. Have you ever had liability insurance refused, declined, canceled, or accepted on special terms? (If YES, explain) Yes No
4. Have you ever used any drug or substance that interfered with your ability to perform Physical Therapy duties? (If YES, explain) Yes No
5. Have you ever been charged with or convicted of any violation of the law other than a minor traffic offense? (If YES, explain) Yes No
6. Do you: do colonic irrigations, treat cancer, epilepsy, practice obstetrics or make a differential diagnosis? (If YES, explain) Yes No
7. Do you ever perform cervical or thoracic adjustments, or do any other Chiropractic adjustment? (If YES, attach explanation) Yes No
8. Do you ever administer injections? (If YES, attach explain) Yes No
9. Do you ever provide Physical Therapy services to a professional athlete? (If YES, explain) Yes No
10. Do you use and technique or therapy other than as taught in the Physical Therapy schools and colleges? (If YES, explain) Yes No
11. Do you ever collect fees before the day on which you render treatment? (If Yes, attach explanation) Yes No
12. Have you (or has a collection agency on your behalf) ever sued a patient to collect fees? (If Yes, attach explanation) Yes No
13. Have you ever treated a person that was previously in a research program you sponsored? (If Yes, attach explanation) Yes No
14. Do you always record the patient's account of his progress, objective findings, and details of treatment procedures? Yes No
15. Do you make a differential diagnosis? Yes No If NO, do you limit your responsibility to treating symptoms? Yes No
16. Do you refer to other health providers? Yes No If YES, circle: MD Ortho Neuro DC LAc RN RPT Other _____
17. Do you treat Medicaid patients? Yes No If YES, what % of your practice is Medi-Cal / Medicaid? _____
18. When do you want your Physical Therapist malpractice insurance to be in effect (may not be before date app is received)? _____
19. List other health professions you are licensed to practice (RN, LMT, LAc, etc.) _____
20. Who provides your malpractice insurance for that profession? _____ Policy Expires: _____
21. Complete the following to extend coverage to an Additional Insured with either Shared Limits or Separate Limits (charges apply as indicated):
 - Shared _____
Limits: Your own Professional Corp or Professional Partnership: Free Any other entity (Landlord, Management Co., etc.): 5% / Entity
 - Separate _____
Limits: Any entity with Separate Limits, regardless of ownership: 10% Charge / Entity, subject to a 20% Minimum Charge (Add sheets if needed)
22. To add Premises Liability (\$75 / location), list address here: _____

COVERAGE AGREEMENT AND SIGNATURE

NO FALSE STATEMENTS: I hereby apply for Professional Liability coverage. I hereby declare that the above statements are true, and I have not misstated or suppressed any facts. I agree and understand that my policy is issued in reliance upon such statements, that such statements are deemed material, that untrue statements could void my insurance and that this declaration shall be a basis of, and form a part of, my policy.

CLAIMS-MADE ONLY: I understand that if coverage is granted, the policy will only cover claims made during the policy period arising out of the rendering of, or failure to render, professional services subsequent to the retroactive date. I understand that if the policy terminates for any reason, there is no coverage for claims reported after the termination date (even though the injury occurred while the policy was in force) unless Extended Coverage is purchased within 30 days after termination.

RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS: I understand that there is no guarantee that coverage will be renewed. I understand that, if coverage is granted, I shall have the duty to report in writing, within 48 hours, or as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written patient complaints, or threats or filings of lawsuits.

RELEASE OF INFORMATION: I hereby authorize release of information from my professional Physical Therapist associations & organizations, any hospitals or insurance carriers, my State Physical Therapy Board, and any other relevant entity to: the National Physical Therapy Council or its agent, for any underwriting or claim-related inquiry. I agree that the organization releasing such information, shall not incur any liability as a result of any information released or furnished pursuant to this authorization, including any errors, omissions or mistakes contained therein. A photocopy of this Release Form will be as valid as the original.

SIGN: _____ **DATE:** _____