



ALLIED MEDICAL COUNSELORS & COUNSELING SUPPLEMENTAL APPLICATION
SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION:

1. Are you in private practice? No Yes
 Please indicate the (%) percent of time spent in the following work locations:
 Administrative Office _____ Patient's Home _____ Professional Office _____
 Classroom _____ Outpatient Clinic _____ Laboratory _____
 Operating Room _____ Nursing Home _____ Emergency Dept. _____
 Hospital Ward (specify) _____ Other (specify) _____ of a Hospital _____
2. If services performed are counseling, indicate the (%) percent of total counseling:
 Family Planning _____ Drug Methadone _____ Legal _____ Crisis Intervention _____
 Marital _____ Alcohol _____ Criminal _____ Adoption Screening _____
 Family _____ Narcotics _____ V.D. _____ Foster Care Screening _____
 Abortion _____ Domestic Abuses _____ Pastoral _____ Other (specify) _____
3. Please provide the percentage of counseling work performed for each of the following age brackets (should equal 100%): Ages: 0-12 _____ 13-18 _____ 19-34 _____ 35 and up _____
4. Please answer the following:
 a. Are you a religiously affiliated or pastoral counselor? No Yes
 b. Number of families in church? No Yes
 c. Is there a charge for counseling services? No Yes
 d. Are counseling sessions kept strictly confidential? No Yes
 e. If "No," explain: _____
 f. Any youth group activities? No Yes
 g. Any overnight activities? No Yes
 h. If "Yes," please describe: _____
 i. Who supervises? _____
 j. How many supervisors? _____
 k. Day Care? No Yes
 If "Yes," number of children, number of staff, hours of operation: _____

5.

EMPLOYEES	NUMBER OF FULL TIME	NUMBER OF PART TIME
Administrators*		
Counselors*		
Psychologists		
Nurses, RN		
Nurses, LPN		
* Indicate Total with Masters		
DEGREE	FULL TIME	PART TIME
Home Health Aids		
Social Workers		
Clerical		
Teachers		
Physicians		
Minister/Priest/Rabbi		
Psychiatrists		

6. Estimated number of outpatient visits in the next 12 months: _____
 Estimated number of outpatient visits in the previous 12 months: _____
 Estimated number of Hot Line Calls in the previous 12 months: _____
7. Is applicant engaged in, associated with, or involved in any other enterprise? No Yes
 If "Yes," provide details: _____
8. List any professional association in which applicant is a member: _____
9. Describe any professional training, licensing or certification needed for this operation: _____
10. Is anyone applying for insurance under this policy aware of any circumstances involving sex with any patients, former patients or relatives thereof? No Yes
 If "Yes," please explain: _____
11. Does anyone applying for insurance under this policy use sex as a form of therapy or believe that it is valid and appropriate? No Yes
 If "Yes," please explain: _____
12. Does anyone applying for insurance under this policy use any form of recovered or repressed memory therapy? No Yes
 If "Yes," please explain: _____
13. Does anyone applying for insurance under this policy testify or consult in child abuse litigation (civil or criminal)? No Yes
 If "Yes," please explain: _____
14. Do you administer any anesthesia? No Yes
 If "Yes," please explain: _____
15. Do you prescribe medications? No Yes
 If "Yes," please explain: _____
16. If you contract your services to others on an independent contractor basis, advise who you contract your work to: _____

DECLARATION AND SIGNATURE:

The undersigned declares that to the best of his/her knowledge the statements in this application and its attachments are true. The company is hereby authorized to make any investigation and inquiry deemed necessary in regard to this application.

 Applicant's Signature

 Sub-Producer

 Title/Date

 Producer

SIGNING THIS FORM DOES NOT BIND THE APPLICANT OR THE COMPANY OR THE UNDERWRITING MANAGER TO COMPANY THE INSURANCE. Application MUST be currently signed, completed and dated to be considered for quotation.