



# Atlantic Specialty Lines, Inc.

## ALLIED MEDICAL PHYSICAL-OCCUPATIONAL THERAPY CENTER SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

### GENERAL INFORMATION:

1. Indicate the number by type of applicant's employees:

\_\_\_\_\_ Physical Therapists                      \_\_\_\_\_ Physical Therapy Assistants  
\_\_\_\_\_ Occupational Therapists                \_\_\_\_\_ Occupational Therapy Assistants  
\_\_\_\_\_ Speech Therapists                        \_\_\_\_\_ Speech Therapy Assistants  
\_\_\_\_\_ Other: \_\_\_\_\_

Indicate each treatment modality used by the applicant:

Short Wave Diathermy                       Ultrasound                       Electrical Stimulation  
 Mechanical Traction                       Galvanic                       Whirlpool  
 Ultraviolet                       Other: \_\_\_\_\_

2. Does applicant provide professional services or conduct business operations away from applicant's professional office? If yes, describe and indicate percentage of overall operations associated therewith: \_\_\_\_\_  No  Yes

3. Does applicant provide physical therapy services only as prescribed by a physician? If no, explain exceptions: \_\_\_\_\_  No  Yes

4. Approximately what percentage of applicant's patients are: \_\_\_\_\_ Under 18                      \_\_\_\_\_ Over 18

5. Approximately what percentage of applicant's practice is associate with sports injuries? \_\_\_\_\_%

6. Has applicant treated any professional or collegiate athletes? If yes, how many in the past year? \_\_\_\_\_  No  Yes

7. Do you contract your services to others on an independent contractor basis? If yes, advise to whom you contract your work: \_\_\_\_\_  No  Yes

8. Do you administer any anesthesia?  No  Yes

9. Does applicant sell, rent or otherwise distribute any products?  No  Yes

10. Is applicant licensed, registered or certified to provide any other professional services except as stated in this application?  No  Yes

11. Is the applicant a proprietor, superintendent, officer, director, stockholder or member of the Board of Directors, trustees or governors of any business enterprises, except as previously stated?  No  Yes

12. Does applicant advertise services in any manner other than listing in the telephone directory?  No  Yes

13. Estimated number of visits in the past 12 months: \_\_\_\_\_

14. Estimated number of visits for the next 12 months: \_\_\_\_\_

15. Has the applicant or the applicant's employees:

- a. Ever been the subject of disciplinary or investigative proceedings or been reprimanded by a governmental or administrative agency, hospital or professional associate?  No  Yes
- b. Ever been convicted for any act committed in violation of any law or ordinance other than a traffic offense?  No  Yes
- c. Ever had state professional license, certificate or registratin refused, suspended, revoked, renewl refused or accepted on special terms or ever voluntarily surrendered same?  No  Yes
- d. Is anyone applying for insurance under this policy aware of any circumstances involving sex with patients, former patients or relatives thereof?  No  Yes
- e. 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," was answered to any of the above, explain: \_\_\_\_\_

\* 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, may be committing a fraudulent insurance act, and may be subject to a civil penalty or fine.

\* not applicable in all states

**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.