

NATIONAL CHIROPRACTIC COUNCIL

Application *for* Membership



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	
Chiropractic License Number(s)	State Issued	Date Issued	Chiropractic College and Location	Year Graduated
Birth Date	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			

Fax or Mail Completed App & Payment to:

SDN INSURANCE AGENCY, LLC

300 Spindrift Drive
Amherst, NY 14221

www.sdnins.com

Phone: 800-728-6362 / 716-633-3400

Fax: 716-633-4306

Email: chiropl@sdnins.com

Payment Detail (See "Rate Sheet" for coverage choices):

Installment Due: _____

Optional Additional Insured (5%) _____

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 for liability coverage through the National Chiropractic Council. I agree to pay this amount according to the terms of the card issuer agreement.

Signature: _____

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Professional Information *(Attach Additional Sheets When Needed)*

1. Is your chiropractic license current? Yes No
2. 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, attach explanation) Yes No
3. Has any board, agency, association, or insurer investigated or taken any action involving you or your license? (If YES, explain) Yes No
4. Have you ever had malpractice insurance denied, canceled, or accepted on special terms? (If Yes, attach explanation) Yes No
5. Have you ever used any intoxicant, narcotic, or other psychoactive drugs which interfered with your ability to perform professional duties; or have you used any illegal drug in the past year? (If Yes, attach explanation) Yes No
6. Have you been charged with or convicted of violating any law other than a minor traffic offense? (If Yes, attach explanation) Yes No
7. Do you ever use stressology, internal coccyx adjustment, magnetic or gemstone therapy, or the Toftness device? (If Yes, explain) Yes No
8. Do you practice obstetrics or colonics? (If Yes, attach explanation) Yes No
9. Do you treat cancer or epilepsy? (If Yes, attach explanation) Yes No
10. Do you ever administer anesthesia (other than topical or by means of local infiltration)? (If Yes, attach explanation) Yes No
11. Do you ever prescribe, dispense, or administer any prescription drugs? (If Yes, attach explanation) Yes No
12. Check to indicate whether you use, or intend to use, in your practice: Manipulation under anesthesia Laser treatment
 Breast Thermography (A separate addendum must be completed and approved to activate coverage for these treatment modalities.)
13. Do you use any technique not taught in the chiropractic schools and colleges? (If Yes, attach explanation) Yes No
14. Do you make a differential diagnosis? Yes No If No, do you limit your responsibility to treating symptoms? Yes No
15. If the quality of an x-ray film inhibits your ability to properly diagnose a patient's condition, will you always require a retake? Yes No
16. Does anyone x-ray patients other than a qualified x-ray technician or licensed x-ray professional? (If Yes, explain) Yes No
17. Do you always require your patients to sign an informed consent prior to treatment? (If Yes, attach copy of form you use) Yes No
18. Do you always record the patient's account of his or her progress? Yes No No, but I will do so now.
19. Do you always record objective findings? Yes No No, but I will do so now.
20. Do you always record details of treatment procedures? Yes No No, but I will do so now.
21. When a patient needs treatment or diagnosis outside your scope of practice, do you refer them to other health providers? Yes No
22. How many patients do you see weekly? _____ How many hours / week do you spend professionally with patients? _____
23. What is the average time you spend professionally with a patient on their first office visit? _____ Follow up visit? _____
24. Do you treat Medicaid/Medi-Cal patients? Yes No If Yes, what % of your practice is Medicaid/Medi-Cal? _____
25. List any practice management company you have used (If none, indicate so): _____
26. Do you ever collect fees for services before the day on which you provide those services? (If Yes, attach explanation) Yes No
27. Have you (or has a collection agency on your behalf) ever sued a patient to collect fees? (If Yes, attach explanation) Yes No
28. Have you ever treated a person that was previously in a research program you sponsored? (If Yes, attach explanation) Yes No
29. Who provides your current chiropractic malpractice policy? _____ Expires: _____
30. Your Chiropractic insurance, if approved, will be effective the date your app is received. For a later date, specify here: _____
31. List any other professional healthcare license you hold (L.Ac., N.D., RN, RPT, etc.): _____
Indicate your malpractice carrier for that other profession: _____ Expires: _____
32. Provide the names and practice type (ND, L.Ac., MD, DO, DC, DPM, RN, PT, etc.) of any healthcare practitioners with whom you work, or share office/reception space, personnel, equipment or letterhead (Attach additional sheets if needed):

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33. Which best describes how you practice: Sole Proprietor Professional Corp. Partnership Employee Contractor
34. To add your corporation, partnership, landlord, or other entity as an Additional Insured, list below, then check whether you require the Additional Insured to have a shared limit (5% cost), or separate limit (20% cost). Add sheets as needed:

_____	Limits: <input type="checkbox"/> Shared	_____	Limits: <input type="checkbox"/> Shared
Name of Additional Insured	<input type="checkbox"/> Separate	Name of Additional Insured	<input type="checkbox"/> Separate

35. List any current chiropractic specialty designations / certifications held: _____
36. List any chiropractic awards, teaching appointments, or published works: _____

37. If you have held hospital privileges or completed a residency, provide the following (Attach additional sheets if needed):

_____	_____	_____
Hospital Name and Location	Dates Affiliated	Nature of Privileges / Reason for Termination

38. List pre-chiropractic college education: _____
- | | | |
|---------|--------------|--------|
| _____ | _____ | _____ |
| College | Yr Graduated | Degree |

➤ Signatures - Member Application for Coverage *(Signatures are required in all FOUR places below)*

NO FALSE STATEMENTS: 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.

1. Sign here: _____ Date: _____

CLAIMS-MADE ONLY *(Applies only if you selected a "Claims Made" Claims Reporting Basis):* I understand that if a policy of insurance is issued based on the statements in this application, except as otherwise provided in that policy, the policy is limited to claims made against the insured during the policy period arising out of the rendering or of failure to render professional services subsequent to the retroactive date. I understand that if the policy terminates due to nonpayment of premium or cancellation by the insured or insurer, there is no coverage for claims reported after the termination date (even though the injury occurred while the policy was in force), unless the insured purchased an Extended Coverage Policy within 30 days after termination.

2. Sign here: _____ Date: _____

RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS: I understand that there is no guarantee that coverage will be renewed. I also understand that any price distinctions based on safe chiropractic practices may be based in part on information provided by me in the future or during future pre-arranged office inspections. 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.

3. Sign here: _____ Date: _____

RELEASE OF INFORMATION: I hereby authorize release of information from my professional chiropractic associations & organizations, any hospitals or insurance carriers, my State Board of Chiropractic Examiners, and any other relevant entity to: the National Chiropractic 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.

4. Sign here: _____ Date: _____