

# 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
Social Security Number	Birth Date	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	

<p><b>Fax or Mail Completed App &amp; Payment to:</b></p> <p><b>National Chiropractic Council</b>  <b>1851 East First Street, Suite 1160</b>  <b>Santa Ana CA 92705</b>  <b>800-622-6869 714-571-1863 (FAX)</b></p>	<p><b>Payment Detail</b> (See "Rate Sheet" for coverage options):</p> <p>Installment Due: .....</p> <p>Optional Arbitration Forms (\$20 / pack) .....</p> <p>Optional Additional Insured (10%) .....</p> <p><b>Total Payment Remitted</b> _____</p>
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### Credit Card Payments, Complete Following:

<p>Card Type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express</p> <p>Card #: _____</p> <p>Expires: _____</p>	<p>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.</p> <p><b>Signature:</b> _____</p>
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### Professional Information *(Attach Additional Sheets When Needed)*

1. Is your chiropractic license current?  Yes  No
2. Has any malpractice claim or proceeding ever been brought against you, your associates or employees; or In the last three years has anyone asserted that your care, treatment or diagnosis was deficient or caused them harm? (If Yes, explain)  Yes  No
3. Has any agency or association ever investigated or taken any action against you or your license? (If Yes, attach explanation)  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 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 perform, or intend to perform in the next year, manipulation under anesthesia? (An MUA addendum must be approved to activate MUA coverage.)  Yes  No
11. Do you ever administer anesthesia (other than topical or by means of local infiltration)? (If Yes, attach explanation)  Yes  No
12. Do you ever prescribe or dispense any prescription drugs? (If Yes, attach explanation)  Yes  No
13. Do you use any technique not taught in the chiropractic schools and colleges? (If Yes, attach explanation)  Yes  No
14. Do you always conduct comprehensive stroke screening prior to doing any cervical adjustment? (If No, explain)  Yes  No
15. Do you make a differential diagnosis?  Yes  No *If No, do you limit your responsibility to treating symptoms?*  Yes  No
16. If the quality of an x-ray film is marginal, do you always do, or order, a retake?  Yes  No
17. Does anyone x-ray patients other than a qualified x-ray technician or licensed x-ray professional? (If Yes, explain)  Yes  No
18. Do you always require your patients to sign an informed consent prior to treatment? (If Yes, attach copy of form you use)  Yes  No
19. Do you always record the patient's account of his or her progress?  Yes  No  No, but I will do so now.
20. Do you always record objective findings?  Yes  No  No, but I will do so now.
21. Do you always record details of treatment procedures?  Yes  No  No, but I will do so now.
22. Do you refer to other health providers?  Yes  No *If Yes, circle: MD Ortho Neuro DC RN RPT Other:* \_\_\_\_\_
23. How many patients do you see weekly? \_\_\_\_\_ How many hours / week do you spend professionally with patients? \_\_\_\_\_
24. What is the average time you spend professionally with a patient on their first office visit? \_\_\_\_\_ Follow up visit? \_\_\_\_\_
25. Do you treat Medicaid/Medi-Cal patients?  Yes  No *If Yes, what % of your practice is Medicaid/Medi-Cal?* \_\_\_\_\_
26. List any practice management company you have used (If none, indicate so): \_\_\_\_\_
27. Do you ever collect fees for services before the day on which you provide those services? (If Yes, attach explanation)  Yes  No
28. Have you (or has a collection agency on your behalf) ever sued a patient to collect fees? (If Yes, attach explanation)  Yes  No
29. Have you ever treated a person that was previously in a research program you sponsored? (If Yes, attach explanation)  Yes  No
30. Who provides your current chiropractic malpractice policy? \_\_\_\_\_ Expires: \_\_\_\_\_
31. Your Chiropractic insurance, if approved, will be effective the date your app is received. For a later date, specify here: \_\_\_\_\_
32. List any other professional healthcare license you hold (L.Ac., N.D., RN, RPT, etc.): \_\_\_\_\_  
Indicate your malpractice carrier for that other profession: \_\_\_\_\_ Expires: \_\_\_\_\_

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33. 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):

\_\_\_\_\_

34. Which best describes how you practice:  Sole Proprietor  Professional Corp.  Partnership  Employee  Contractor

35. 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 (10% cost), or separate limit (40% 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

36. List any current chiropractic specialty designations / certifications held: \_\_\_\_\_

37. List any chiropractic awards, teaching appointments, or published works: \_\_\_\_\_

\_\_\_\_\_

38. 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

39. 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 that I have not suppressed or misstated any facts, and I agree that this declaration shall be a basis of the contract and form a part of my malpractice insurance policy. I understand that untrue statements could void my insurance 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: \_\_\_\_\_