



Quaker Special Risk
Telephone: (800) 447-4180
Website: www.qsr-insurance.com

OUTPATIENT THERAPY APPLICATION
ATTACH SEPARATE SHEET WITH ANY ADDITIONAL DETAILS IF NECESSARY

Name of Entity (Including All DBAs):

Mailing Address:

Location Address(es):

Website Address:

Tax Identification Number: Telephone Number: ()

Person to contact for survey: Name Title

Email Address:

Number of years entity under current ownership Number of years' experience in the field

Applicant is Individual Partnership Corporation Other

Is applicant licensed to do business in the states listed above where required? Yes No

Is applicant a member of any national or regional network or association? Yes No

If yes, please provide names of associations.

PAST 12 MONTHS

Annual Gross Revenue \$

Annual Payroll \$

Annual number of Client Contacts

ESTIMATED FOR NEXT 12 MONTHS

Annual Gross Revenue \$

Annual Payroll \$

Annual number of Client Contacts

Please provide list of all services provided.

How many employees/independent contractors do you employ in each of the following positions?

Physical Therapists Physical Therapy Assistants
Occupational Therapists Speech Therapists
Massage Therapists All others, please describe

Do you keep daily work reports on all patients as they are seen? Yes No

Approximately what percentage of applicant's patients are under the age of 18? %

Approximately what percentage of applicant's practice is associated with sports injuries? %

Has applicant treated any professional or collegiate athletes? Yes No If yes, please answer the following questions:

How many professional athletes treated in the past 12 months? _____
 How many collegiate athletes treated in the past 12 months? _____
 What is the level of injury being treated? _____
 What services are being provided? _____
 Is each athlete required to sign a waiver prior to services being provided? Yes No

Do you offer aquatic therapy? Yes No If yes, please answer the following questions:
 Is there a therapist with each patient at all times? Yes No
 Do you have any type of patient lift to get in and out of the pool? Yes No
 Do you ensure that the pool deck area is free of any debris to help prevent falls? Yes No
 How often is the pool maintained? _____
 What is the temperature of the pool? _____
 How deep is the pool? _____

Is the pool ever used for anything other than therapy? Yes No If yes, please explain. _____

Do you offer dry needling or acupuncture services? Yes No
 If yes, please complete supplemental application.

Do you offer any fitness classes or other type of wellness services? Yes No
 If yes, please complete supplemental application.

Do you provide any spinal manipulations? Yes No
 If yes, do you monitor and keep on file the certifications and education requirements required by the state to confirm that the treating therapist remains in compliance? Yes No

Are any tests conducted/results interpreted or diagnosed by the applicant? Yes No
 If yes, please explain. _____

Do you sell any products? Yes No
 If yes, please provide complete list of products sold.

PROFESSIONAL LIABILITY – PRIOR CARRIER INFORMATION

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							
3rd Prior Yr.							
4th Prior Yr.							

GENERAL LIABILITY – PRIOR CARRIER INFORMATION

Company	Policy Number	Policy Period	Claims Made or Occurrence	Retro Date	Policy Limits	Deductible	Annual Premium
Current Yr.							
Prior Yr.							
2nd Prior Yr.							

3 rd Prior Yr.							
4 th Prior Yr.							

Has the applicant had any Professional or General Liability claims in the past five years? Yes No

Is the applicant aware of any prior incident, circumstance or occurrence that may result in a future claim?
 Yes No If yes, attach full details.

Has applicant had any incidents or claims reported for sexual misconduct or any other allegations of abuse?
 Yes No If yes, attach full details.

Has any company cancelled, declined or refused to issue similar insurance? Yes No
 If yes, please explain. _____

Does applicant require all insureds, including employees and contractors, to report ALL incidents to the Named Insured no later than the end of the work day in which the incident occurred? Yes No
 If no, please explain. _____

Check all the following that apply as part of each employee screening and hiring process:

- | | |
|---------------------------------|------------------------------------|
| Applications _____ | Multi-state Registry _____ |
| Drug / HIV / Hep. Testing _____ | Criminal Background Checks _____ |
| Education/Competency _____ | Licenses/Annual Confirmation _____ |
| Reference Verification _____ | |

Are employees required to actively participate in continuing education? Yes No

Do you have a formal written quality assurance and risk management program? Yes No

Person Responsible: _____ Title: _____

Are there written guidelines in place regarding sexual misconduct or physical abuse? Yes No

Do you assess **all** clients to determine impairment of any kind prior to a therapy session? Yes No

If it is determined that the client should not participate in their therapy session, what action is taken? _____

Is the client's file documented of this assessment and subsequent action? Yes No

Does your manual of policies and procedures contain a section on assessing and addressing issues tied to use of controlled substances/opioids by either clients or employees? Yes No

Has the applicant or any of its employees/contractors ever been subject to any of the following? If yes to any question, please attach full details.

Subject to disciplinary action or investigatory proceedings or reprimanded by any administrative or government agency, hospital or professional association? Yes No

Has any professional license been refused, suspended, revoked, renewal refused or accepted only with special terms or has applicant or any of its employees voluntarily surrendered any professional license? Yes No

Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? Yes No

DATA BREACH QUESTIONS

What operating system does the applicant use? (ex. Windows 7, 8, 10, etc.) _____

How often does the applicant perform Windows updates? _____

What anti-virus software does the applicant use? _____

Does the applicant use firewall technology? Yes No

Is the anti-virus software installed on all of the applicant's/employees' business computer systems, including laptops, personal computers, and networks? Yes No

Does the applicant use intrusion detection software to detect unauthorized access to internal networks and computer systems? Yes No

Is it the applicant's policy to upgrade all security software as new releases or improvements become available? Yes No

Does the applicant provide remote access to its network? Yes No
If yes, is remote access restricted to Virtual Private Networks (VPNs)? Yes No

This insurance does not apply to any of the following: physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, and psychiatrist. Unless otherwise provided by endorsement, these medical professional occupations are excluded from coverage. The insurance described herein is subject to all terms, conditions and exclusions of the insurance certificate.

YOUR APPLICATION CANNOT BE PROCESSED UNLESS COMPLETED IN ITS ENTIRETY.

Applicant's Warranty Statement: The undersigned represents to the best of his/her knowledge and belief the particulars and statements set forth are true and agree that those particulars and statements are material to the acceptance of the risk assumed by the Company. The undersigned further declares that any claim, incident or event taking place prior to the effective date of the insurance applied for which may render inaccurate, untrue, or incomplete any statement made will immediately be reported in writing to the Company and the Company may withdraw or modify any outstanding quotations and/or authorization or agreement to bind the insurance. The signing of the Application does not bind the undersigned to purchase the insurance, nor does the review of the Application bind the Company to issue a policy. It is understood the Company is relying on the Application in the event the Policy is issued. It is agreed that this Application, including any material submitted therewith, shall be the basis of the contract should a policy be issued, and may be attached to and become part of the policy.

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 commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Must be signed by principal, partner or officer of group or individual applying for insurance.

Signature of Applicant _____

Printed Name _____

Title _____

Date _____

PLEASE PROVIDE COPIES OF THE FOLLOWING CURRENT POLICY DECLARATION PAGES SHOWING EFFECTIVE DATES, RETRO DATES AND LIMITS, SO UNDERWRITING CAN MATCH LIMITS AND APPLICABLE RETROACTIVE DATES.

Professional Liability
General Liability
Physical and Sexual Abuse
Employee Benefits Liability (if coverage needed)
Hired and Non-owned Auto Liability (if coverage needed)