1. Applicant’s Name: ________________________________________________________________

2. List full names of all individuals or partners and their interests.
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

3. Applicant’s Professional Specialty ______________________________________________

4. Is applicant in private practice? ______________________________ or an employee? __________

5. Indicate the percent of time spent in the following work locations:
   ___% Administrative Office ___% Laboratory
   ___% Classroom ___% Patient’s Home
   ___% Hospital (be specific) ___% Professional Office
   _____________________________ ___% Operating Room
   ___% Other (be specific) ___% Outpatient Clinic

6. Please check the type of service provided:
   ___ Aide or Assistant ___ Nutrition - Diets
   ___ Audiology ___ Private Counseling
   ___ Contact Lens Technician-Optician ___ Psychology (Private Practice Only)
   ___ Dental Hygiene ___ Social Work
   ___ External Prosthetic Device ___ Swimming Instructor
   ___ Guidance ___ Therapy (Occupational, Physical, Respiratory, Speech)
   ___ Home Health Care ___ Other (be specific)
   ___ Hospice ___ Marriage
   ___ Non-Profit Counseling (be specific) ______________________________
   ___ Non-Profit Referral Only – Hotlines (be specific) ______________________

7. Indicate the number of:
   Receipts
   Outpatient Visits (Number of visits per year)
   Individual Professional Employees
   Payroll
Participants _____
Other (be specific) _____

8. List any professional association in which applicant is a member: __________________________

__________________________________________________________

Describe any professional training, licensing or certification needed for this operation: ______

__________________________________________________________

9. If you are an employee, please advise if you have any management or supervisory duties. ______

__________________________________________________________

If so, what are they? ________________________________

10. Do you administer any anesthesia? _____ Yes _____ No

11. If you contract your services to others on an independent contractor basis, please advise to whom you contract your work? ________________________________

__________________________________________________________

**COVERAGE IS NOT BINDING UNTIL APPROVED BY THE COMPANY.**

Applicant’s Signature ____________________________________________

Date: __________________________________________________________