Commonwealth Underwriters Ltd.
P.O. Box 5441 Richmond, VA 23220
Phone: 800-396-6226
Fax: 888-359-6994
www.commund.com

ALLIED MEDICAL COUNSELORS & COUNSELING SUPPLEMENTAL APPLICATION

SUBMIT WITH ALLIED MEDICAL GENERAL APPLICATION

GENERAL INFORMATION:

1. Are you in private practice? ☐ No ☐ Yes

   Please indicate the (%) percent of time spent in the following work locations:

Administrative Office	_____	Patient's Home	_____	Professional Office	_____
Classroom	_____	Outpatient Clinic	_____	Laboratory	_____
Operating Room	_____	Nursing Home	_____	Emergency Dept.	_____
Hospital Ward (specify)	_____	Other (specify)	_____	of a Hospital	

2. If services performed are counseling, indicate the (%) percent of total counseling:

Family Planning	____	Drug Methadone	____	Legal	____	Crisis Intervention	____
Marital	____	Alcohol	____	Criminal	____	Adoption Screening	____
Family	____	Narcotics	____	V.D.	____	Foster Care Screening	____
Abortion	____	Domestic Abuses	____	Pastoral	____	Other (specify)	____

3. Please provide the percentage of counseling work performed for each of the following age brackets (should equal 100%): Ages: 0-12 _____ 13-18_____ 19-34 _____ 35 and up_____

4. Please answer the following:
   a. Are you a religiously affiliated or pastoral counselor? ☐ No ☐ Yes
   b. Number of families in church? ☐ No ☐ Yes
   c. Is there a charge for counseling services? ☐ No ☐ Yes
   d. Are counseling sessions kept strictly confidential? ☐ No ☐ Yes
   e. If "No," explain:_____
   f. Any youth group activities? ☐ No ☐ Yes
   g. Any overnight activities? ☐ No ☐ Yes
   h. If "Yes," please describe:_____
   i. Who supervises?_____
   j. How many supervisors?_____
   k. Day Care? ☐ No ☐ Yes
      If "Yes," number of children, number of staff, hours of operation:_____
      _____

5.

EMPLOYEES	NUMBER OF FULL TIME	NUMBER OF PART TIME
Administrators*		
Counselors*		
Psychologists		
Nurses,RN		
Nurses, LPN		
*Indicate Total with Masters		
DEGREE	**FULL TIME**	**PART TIME**
Home Health Aids		
Social Workers		
Clerical		
Teachers		
Physicians		
Minister/Priest/Rabbi		
Psychiatrists		

6. Estimated number of outpatient visits in the next 12 months: _____
   Estimated number of outpatient visits in the previous 12 months: _____
   Estimated number of Hot Line Calls in the previous 12 months: _____

7. Is applicant engaged in, associated with, or involved in any other enterprise? ☐ No ☐ Yes
   If "Yes," provide details: _____

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

9. Describe any professional training, licensing or certification needed for this operation: _____

10. Is anyone applying for insurance under this policy aware of any circumstances involving sex with any patients, former patients or relatives thereof? ☐ No ☐ Yes
    If "Yes," please explain: _____

11. 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," please explain: _____

12. Does anyone applying for insurance under this policy use any form of recovered or repressed memory therapy? ☐ No ☐ Yes
    If "Yes," please explain: _____

13. Does anyone applying for insurance under this policy testify or consult in child abuse litigation (civil or criminal)? ☐ No ☐ Yes
    If "Yes," please explain: _____

14. Do you administer any anesthesia? ☐ No ☐ Yes
    If "Yes," please explain: _____

15. Do you prescribe medications? ☐ No ☐ Yes
    If "Yes," please explain: _____

16. If you contract your services to others on an independent contractor basis, advise who you contract your work to: _____

* 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.