



AMERICAN MASSAGE COUNCIL

Membership Application



CONTACT DATA

Full Name (First, Middle, Last)		Practice / Clinic Name			
Office or Mailing Address (include Suite #)		City	State	Zip	
Office Phone	Alternate Phone (Home, Cell, etc.)	Fax	Email		
Massage License #	State Issued	Date Issued	Massage School Attended	Graduated On	Hours Training

PROFESSIONAL INFORMATION

- Is your Massage license issued by: State City N/A Is your Massage license current? (Attach Copy) Yes No
- 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, explain) Yes No
- Has any agency or association investigated or taken any other action against you or your license / certification? (If YES, explain) Yes No
- Have you ever had liability insurance refused, declined, canceled, or accepted on special terms? (If YES, explain) Yes No
- Have you ever used any drug or substance that interfered with your ability to perform Massage duties? (If YES, explain) Yes No
- Have you ever been convicted of any violation of the law other than a minor traffic offense? (If YES, explain) Yes No
- Do you: do colonic irrigations, treat cancer, epilepsy, practice obstetrics, or make a differential diagnosis? (If YES, explain) Yes No
- Have you ever provided Massage services to a professional athlete? (If YES, explain) Yes No
- Are you providing any Massage service that was not a part of your massage school training program? (If YES, explain) Yes No
- List any other health designation you hold (RN, L.Ac, etc.) _____ Do you separately cover these for malpractice? Yes No
- Who provides your current massage malpractice coverage? _____ Policy Expires _____
- To add Premises Liability (\$50 / location), list address here: _____
- List any entity you want as an additional insured (\$10 / entity): _____
- Your Massage insurance, if approved, will be effective the date your app is received. For a later date, specify here: _____

PAYMENT

Membership and Coverage	\$99.00
Additional Insured @ \$10 / Entity	
Premises Liability @ \$50 / Location	
TOTAL PAYMENT REMITTED	

Pmt Type: Check MasterCard Visa AMEX

Card #: _____ Exp: _____

AGREEMENT & SIGNATURE

\$1,000,000 / \$3,000,000 PROFESSIONAL LIABILITY COVERAGE

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.

CLAIMS-MADE ONLY: I understand that if coverage is granted, the policy will only cover claims made 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 for any reason, there is no coverage for claims reported after the termination date (even though the injury occurred while the policy was in force), unless Extended Coverage is purchased within 30 days after termination.

RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS: I understand that there is no guarantee that coverage will be renewed. 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.

SIGN: _____ DATE: _____

FAX OR MAIL COMPLETED APPLICATION TO:



AMERICAN MASSAGE COUNCIL
1100 W. Town & Country Rd., Ste. 1400
Orange, California 92868
800-500-3930 Phone 714-571-1863 Fax