American Association of Holistic Health Practitioners 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 _____

School Attended (Students provide School attending and expected completion info) _____ Graduated _____ Hours Completed _____

Professional Information

1. What current Holistic Health Professional (HHP) Certification do you hold? ❒ AINM ❒ Other _____ ❒ None
2. 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
3. Has any board, agency, association, or insurer investigated or taken any action involving you or your certification? (If *YES*, explain) ❒ Yes ❒ No
4. Have you ever had liability insurance refused, declined, canceled, or accepted on special terms? (If *YES*, explain) ❒ Yes ❒ No
5. Have you ever used any drug or substance that interfered with your ability to perform HHP duties? (If *YES*, explain) ❒ Yes ❒ No
6. Have you ever been charged with or convicted of any violation of the law other than a minor traffic offense? (If *YES*, explain) ❒ Yes ❒ No
7. Do you: do colonic irrigations, treat cancer, epilepsy, practice obstetrics, or make a differential diagnosis? (If *YES*, explain) ❒ Yes ❒ No
8. Have you ever provided nutritional, herbal or HHP services to a professional athlete? (If *YES*, explain) ❒ Yes ❒ No
9. Are you providing any HHP service or advice that was not a part of your HHP school training program? (If *YES*, explain) ❒ Yes ❒ No
10. List any other health designation you hold (RN, LMT, etc.) _____ Do you separately cover these for malpractice? ❒ Yes ❒ No
11. Who provides your current HHP malpractice coverage? _____ Policy Expires _____
12. To add Premises Liability *($75 / location)*, list address here: _____
13. List any entity you want as an additional insured *($10 / entity)*: _____
14. Your HHP liability insurance, if approved, will be effective the date your app is received. For a later date, specify here: _____

Payment

Membership and Coverage	$396.00
Additional Insured @ $10 / Entity	
Premises Liability @ $75 / Location	
Total Payment Remitted	

Pmt Type: ❒ Check ❒ MasterCard ❒ Visa ❒ AMEX

Card #: _____ Exp: _____

Fax or Mail Application To:

American Association of Holistic Health Practitioners
1100 W. Town & Country Rd., Ste. 1400
Orange, CA 92868
800-860-8330 Phone 714-571-1863 Fax

Agreement & Signature

$1,000,000 / $3,000,000 Professional Liability Coverage

Declaration and Authorization: I, the applicant, represent that: 1) I am applying for membership/coverage; 2) I signed/typed my name in the place(s) provided herein; and 3) The above statements are true, and I have not misstated or suppressed any facts. I understand that: 1) If coverage is granted, my Policy is issued in reliance upon such statements; 2) Such statements are deemed material; 3) Untrue statements could void my insurance; 4) This declaration shall be the basis of, and form a part of, my Policy; 5) There is no guarantee that coverage will be renewed; and 6) The Policy requires that I report, in writing, within 3 days, or as soon as practicable, incidents reasonably likely to involve this insurance, including oral or written patient complaints, threats, or lawsuits. If coverage is granted, I authorize you to: 1) Process payments when due, including any installments, by charging the Credit Card provided, in compliance with issuer agreements and U.S. law, and agree that this authority will remain in effect until I have canceled it in writing; 2) Request and receive information about me, for any underwriting or claim-related inquiry, from any professional association, licensing board or healthcare organization; and 3) Opt me in and allow the Company to communicate with me through Email, Fax, Phone, and SMS/ MMS messaging or other text messaging platforms.

Claims Made Policy: I understand that if coverage is granted, my Policy will be limited to claims made against me during the Policy period arising out of the rendering of, or failure to render, professional services subsequent to the retroactive date. I understand that the Claims Made option provides 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 I purchase Extended Coverage within 30 days after termination.

Sign: _____ **Date:** _____