



# TRAINING PROGRAM APPLICATION

## A1. Identifying Information:

Organization Name \_\_\_\_\_ Primary Contact Name/Title \_\_\_\_\_

Primary Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Training Program Title – Description of Program \_\_\_\_\_

## A2. Application Submission Instructions:

1. Please Answer all questions completely. Attach additional sheets if necessary.

2. Once Complete, submit your application for quote to:

**AMERICAN ACUPUNCTURE COUNCIL**  
 1851 E. 1<sup>st</sup> Street, Suite 1160  
 Santa Ana, CA 92705  
[www.acupuncturecouncil.com](http://www.acupuncturecouncil.com)  
 Telephone: (800) 838-0383  
 Fax: (714) 571-1863

## B. Training Program Data

1. At each Training Event do you always require your Instructors, Students and/or other patients to sign an informed consent prior to receiving Professional Services? (If **Yes**, attach copy of form used)  Yes  No  
 If **No**, please explain: \_\_\_\_\_
2. Does anyone receive Professional Services at the Training Event(s) other than the Instructors and/or Students?  Yes  No  
 If **No**, please skip to Question 3.
  - a. Do you maintain a written log of all the patients that receive services during your training program?  Yes  No  
 If **No**, please explain: \_\_\_\_\_
  - b. At each Training Event is the care provided by Instructors and Students limited to Program description?  Yes  No  
 If **No**, please explain: \_\_\_\_\_
  - c. Does each Trainee wear an identifying name tag which clearly includes the word "TRAINEE"?  Yes  No  
 If **No**, explain how patients are informed that treatment is being rendered by a Training Program Participant:  
 \_\_\_\_\_
3. Are there any other doctors or health practitioners, including medical doctors, doctors of osteopathy, doctors of chiropractic, podiatrists, nurses, anesthetists, physical therapists, or acupuncturists not listed elsewhere on this application that will render healthcare services during the training program?  Yes  No

7. For each proposed Training Event, please list the dates, course title. And hours of training (Attach additional sheets if needed)

Date(s)	Course Title	Hours	Date(s)	Course Title	Hours

8. Do you anticipate any Training Event(s) during the next twelve months other than those listed above?  Yes  No

9. **Proper Licensing:** All Instructors at a Training Event must be licensed or certified for the practice of acupuncture, and must have completed such additional training and/or certification as may be legally required to enable each Instructor to supervise Students and treat patients within the state where the training program is being held.

10. **Reporting Requirement:** For coverage to apply, the following information for each Training Event must be reported prior to the applicable report due date indicated on the training program endorsement: Training Site, Training Start and Training End Dates, and Training Participants, including both Instructors and Students. Furthermore, all information required for each training event must be reported to the Company in writing.

### C. Signatures (Please sign and date in all **FOUR** places.)

**NO FALSE STATEMENTS:** I hereby declare that the above statements are true and that I have not suppressed or misstated any facts and I agree that this declaration shall be a basis of the contract and form a part of my malpractice insurance policy. I understand that untrue statements could void my insurance policy.

1. **Sign here:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**CLAIMS-MADE ONLY** (Does not apply if your Claims Reporting Basis is Occurrences): I understand that if a policy of insurance is issued based on the statements in this application, except as otherwise provided in that policy, the policy is limited to claims made against the insured 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 due to nonpayment of premium or cancellation by the insured or insurer, there is no coverage for claims reported after the termination date (even though the injury occurred while the policy was in force) unless the insured purchased an Extended Coverage Policy within 30 days after termination.

2. **Sign here:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS:** I understand that there is no guarantee that coverage will be renewed. I also understand that any price distinctions based on safe acupuncture practices may be based in part on information provided by me in the future or during future pre-arranged office inspections. 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.

3. **Sign here:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**RELEASE OF INFORMATION:** I hereby authorize release and exchange of information from: My professional acupuncture associations, organizations, societies, any hospitals I presently or previously held staff privileges with, insurance carriers, trusts, administrators, etc., in past and future underwriting and claims matters, State Board of Acupuncture Examiners, and credit agencies to: the American Acupuncture Council or an investigator employed by the American Acupuncture Council. I further agree that the organization releasing or obtaining the information, its agents, servants and employees, shall not incur any liability as a result of any information released or furnished pursuant to this authorization including any errors, omissions or mistakes contained in such released information. I agree that a photocopy of this Release of Information form will be as valid as the original.

4. **Sign here:** \_\_\_\_\_ **Date:** \_\_\_\_\_