DOCTORS professional liability

Supplemental Application Medical Spa / Anti-Aging Clinics

Full Name of Applicant: _____

NOTE: Note all questions may apply to you. Please do not leave any questions blank. If they do not apply please write N/A for the ones that do not apply.

OPERATIONS

1. What is the professional specialty of the clinic?

   _____

2. (a) Provide list of the Applicants Medical Director(s): _____

   _____

   (b) Attach a CV for each of the applicants medical directors and a description of their duties.

3. Provide the percentage of the Applicant's patients/clients in the following categories:

Acupuncture	%
Beauty Shop (nails, hair, facials)	%
Chelation Therapy	%
Dental	%
Dermatology	%
Hormone Therapy	%
Massage	%
Medical Spa	%

Plastic Surgery	%
Research or Experimental	%
Sclerotherapy	%
Surgical	%
Weight Control	%
Other (specify)	%
	%
TOTAL	**100%**

4. Applicant's practice is run by:

	Doctor
	Dentist
	Dermatology
	Plastic Surgeon

	Nurse
	Administrator
	Other – describe

PROFESSIONAL SERVICES

1. List all manufactured equipment and drugs used in the applicants practice and the purpose for which each is used. Attach separate sheet if necessary:

Equipment/Drug	Purpose	Used only as approved by the FDA? (Yes or No)	If NO, describe off-label usage
		YES ☐ NO ☐	
		YES ☐ NO ☐	
		YES ☐ NO ☐	

2. Does the applicant take before and after picture of every patient? YES ☐ NO ☐

   If No, explain. _____

   _____

3. Must all clients sign a patient consent form specific to the procedures to be performed prior to treatment? YES ☐ NO ☐
If No, explain. _____

_____

PROCEDURES

1. Botox Injections

Does the applicant perform Botox Injections? YES ☐ NO ☐

If yes, complete the following:

(a) Total number of Botox Injections: Past 12 months: _____ Next 12 months _____

(b) Who performs Botox Injections?

_____ Physicians _____ Physicians Assistant _____ Nurse

_____ Dentists _____ Nurse Practitioner _____ Other _____

(c) Have all staff performing Botox injections:

- Receive a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate response to complications, and hands-on performance of at least one procedure on a live patient? YES ☐ NO ☐
- Performed a minimum of ten procedures on live patients YES ☐ NO ☐

(d) Does the applicant have a physician available for consultation and complications YES ☐ NO ☐

If yes,

- Has the physicians completed a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate response to complications, and hands-on performance of at least one procedure on a live patient? YES ☐ NO ☐
- Does the physician have Medical Malpractice Liability Insurance for this activity? YES ☐ NO ☐

2. Chemical Peels

Does the applicant perform Chemical Peels? YES ☐ NO ☐

If yes, complete the following:

(a) Total number of Chemical Peels with solution strength <30%: Past 12 months: _____ Next 12 Months _____

- Who performs Chemical Peels with solution strength <30%:

_____ Physicians _____ Physicians Assistant _____ Nurse

_____ Dentists _____ Nurse Practitioner _____ Other _____

- Have all staff performing Chemical Peels with solution strength <30% received a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate response to complications, and hands-on performance of at least one procedure on a live patient? YES ☐ NO ☐

(b) Total number of Chemical Peels with solution strength >30%: Past 12 months: _____ Next 12 Months _____

- Who performs Chemical Peels with solution strength >30%:

_____ Physicians _____ Physicians Assistant _____ Nurse

_____ Dentists _____ Nurse Practitioner _____ Other _____

- Are all staff performing Chemical Peels with solution strength >30% licensed physicians with a specialty of Dermatology or Plastic Surgery? YES ☐ NO ☐

3. Dermal Fillers

Does the applicant perform Dermal Fillers (Artefill, Collagen, Hylaform, Restylane)? YES ☐ NO ☐

If yes, complete the following:

(a) Total number of Botox Injections: Past 12 months: _____ Next 12 Months _____

(b) Who performs Botox Injections?

_____ Physicians _____ Physicians Assistant _____ Nurse

_____ Dentists _____ Nurse Practitioner _____ Other _____

(c) Have all staff performing Dermal Fillers:

– Received a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate response to complications, and hands-on performance of at least one procedure on a live patient? YES ☐ NO ☐

– Perform a minimum of five procedures on live patients? YES ☐ NO ☐

(d) Does the applicant have a physician available for consultation and complications? YES ☐ NO ☐

If, Yes,

– Has this physicians completed a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate response to complications, and hands-on performance of at least one procedure on a live patient? YES ☐ NO ☐

– Does the physician have Medical Malpractice Liability Insurance for this activity? If, No submit a separate application for each physician to be included. YES ☐ NO ☐

(e) Does the applicant

– Use only dermal fillers approved by the FDA? YES ☐ NO ☐

If no, explain: _____

– Disclose off-label use to all patients receiving such treatment on the patient consent form? YES ☐ NO ☐

4. Laser Skin Treatments

Does the applicant perform Laser Skin Treatments including laser hair removal, IPL, Acne Blue Treatments, and Laser vein treatments? YES ☐ NO ☐

If yes, complete the following:

(a) Total number of Laser Skin Treatments: Past 12 months: _____ Next 12 Months _____

(b) Who performs Laser Skin Treatments?

_____ Physicians _____ Physicians Assistant _____ Nurse

_____ Dentists _____ Nurse Practitioner _____ Other _____

(c) Does the applicant comply with the following standards of practice:

– Individuals are trained in laser physics, tissue interaction, laser safety, clinical application, pre-operative care, and post –operative care of the laser patient. YES ☐ NO ☐

– Prior to the initiation of any patient care activity the individual has read and sign the clinics policies and procedures regarding the safe use of lasers. YES ☐ NO ☐

– Continuing education of all licenses medical professional is mandatory and made available with reasonable frequency to help insure adequate performance. YES ☐ NO ☐

– A minimum of ten procedures of precepted training is required for each laser procedure and laser type to assess competency. Participation in all training programs, acquisition of new skills and number of hours spent in maintain proficiency is well documented. YES ☐ NO ☐

– After demonstrating competency to act alone, the designated licensed medical professional may perform limited laser treatments on specific patients as directed by the supervising physician. YES ☐ NO ☐

(d) Does the applicant comply with the following standards of practice for non-physicians use of laser related technology:

- Any physician who delegates a procedure to a non-physicians must be qualified to do these laser procedures themselves by virtue of having receive appropriate training in physics, safety, surgical technique, pre and post operative care, and be able to handle the resultant emergencies or sequela. YES ☐ NO ☐
- Any licensed medical professional employed by a physician to perform a procedure has received appropriate documented training and education in the safe and effective use of each system and are a licensed medical professional in the state of practice. YES ☐ NO ☐
- A properly trained and licensed medical professional carries out these specifically designed procedures only under the direct, on-site physician supervision and following written procedures. YES ☐ NO ☐
- The supervising physician is available on-site to respond to any untoward event that may occur. Ultimate responsibility lies with the supervising physician. YES ☐ NO ☐

5. Massage Therapy / Cellulite Treatments

Does the applicant perform Massage Therapy / Cellulite Treatments? YES ☐ NO ☐

If yes, complete the following:

(a) Total number of Laser Massage Therapy / Cellulite Treatments: Past 12 months: _____ Next 12 Months _____

(b) Who performs Massage Therapy / Cellulite Treatments?

_____ Physicians _____ Physicians Assistant _____ Nurse

_____ Dentists _____ Nurse Practitioner _____ Other _____

(c) Are all staff performing Massage Therapy / Cellulite Treatments licensed, registered or certified according to state requirements? YES ☐ NO ☐

If No, explain. _____

6. Mesotherapy and / or Lipodissolve

Does the applicant perform Mesotherapy and / or Lipodissolve at this clinic? YES ☐ NO ☐

If yes, complete the following:

(a) Total number of Mesotherapy and / or Lipodissolve: Past 12 months: _____ Next 12 Months _____

(b) Who performs Mesotherapy and / or Lipodissolve?

_____ Physicians _____ Physicians Assistant _____ Nurse

_____ Dentists _____ Nurse Practitioner _____ Other _____

(c) Are all staff Mesotherapy and/or Lipodissolve licensed physicians with a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate response to complications, and hands-on performance of at least one procedure on a live patient? YES ☐ NO ☐

7. Microdermabrasions

Does the applicant perform Microdermabrasions? YES ☐ NO ☐

If yes, complete the following:

(a) Total number of Microdermabrasions: Past 12 months: _____ Next 12 Months _____

(b) Who performs Microdermabrasions?

_____ Physicians _____ Physicians Assistant _____ Nurse

_____ Dentists _____ Nurse Practitioner _____ Other _____

(c) Have all staff performing Microdermabrasions treatments received a minimum of eight hours training including specific training for the equipment being used, skin typing, contraindications, potential complications, and performance of at least one procedure on a live patient? YES ☐ NO ☐

If no, explain: _____

8. Micropigmentation / Permanent Makeup

Does the applicant perform Micropigmentation / Permanent Makeup? YES ☐ NO ☐

If yes, complete the following:

(a) Total number of Micropigmentation / Permanent Makeup: Past 12 months: _____ Next 12 Months _____

(b) Who performs Micropigmentation / Permanent Makeup?

_____ Physicians _____ Physicians Assistant _____ Nurse

_____ Dentists _____ Nurse Practitioner _____ Other _____

(c) Have all staff performing Micropigmentation / Permanent Makeup treatments received a minimum of eight hours training including specific training for the equipment being used, skin typing, contraindications, potential complications, and performance of at least one procedure on a live patient? YES ☐ NO ☐

If no, explain: _____

9. Sclerotherapy Injections

Does the applicant perform Sclerotherapy Injections? YES ☐ NO ☐

If yes, complete the following:

(a) Total number of Sclerotherapy Injections: Past 12 months: _____ Next 12 Months _____

(b) Who performs Sclerotherapy Injections?

_____ Physicians _____ Physicians Assistant _____ Nurse

_____ Dentists _____ Nurse Practitioner _____ Other _____

(c) Are all staff performing Sclerotherapy Injections physicians who have recieved a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate response to complications, and hands-on performance of at least one procedure on a live patient? YES ☐ NO ☐

10. Tattoo Removals

Does the applicant perform Tattoo Removals? YES ☐ NO ☐

If yes, complete the following:

(a) Total number of Tattoo Removals: Past 12 months: _____ Next 12 Months _____

(b) Who performs Tattoo Removals?

_____ Physicians _____ Physicians Assistant _____ Nurse

_____ Dentists _____ Nurse Practitioner _____ Other _____

(c) Are all staff performing Tattoo Removals licensed physicians who comply with the following standards of practice:

– Physicians are trained in laser physics, tissue interaction, laser safety, clinical application, pre-operative care, and post –operative care of the laser patient. YES ☐ NO ☐

– Prior to the initiation of any patient care activity the individual has read and sign the clinics policies and procedures regarding the safe use of lasers. YES ☐ NO ☐

– Continuing education of all licenses medical professional is mandatory and made available with reasonable frequency to help insure adequate performance. YES ☐ NO ☐

11. Surgical or Minor Surgical / Invasive Procedures

Does the applicant perform Minor Surgical / Invasive Procedures? YES ☐ NO ☐

If yes, complete the following:

(a) Total number of Minor Surgical / Invasive Procedures: Past 12 months: _____ Next 12 Months _____

(b) Who performs surgical and/or minor surgical / Invasive Procedures? _____

_____

(c) Provide a complete list of all surgical and minor surgical / invasive procedures being performed (attached a separate sheet if necessary):

_____

_____

_____

_____

_____

_____

_____

_____

NOTICE TO THE APPLICANT - PLEASE READ CAREFULLY

The policy applied for is SOLELY AS STATED IN THE POLICY, if issued, which provides coverage on a "CLAIMS MADE" basis for ONLY THOSE "CLAIMS" THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD, unless the Optional Extension Period option is exercised in accordance with the terms of the policy.

The underwriting manager, Company and/or affiliates thereof is authorized to make any inquiry in connection with this application. Signing this application does not bind the Company to provide or the Applicant to purchase the insurance.

This application, information submitted with this application and all previous applications and material changes thereto of which the underwriting manager, Company and/or affiliates thereof receives notice is on file with the underwriting manager, Company and/or affiliates thereof and is considered physically attached to and part of the of the policy if issued. The underwriting manager, Company and/or affiliates thereof will have relied upon this application and all such attachments in issuing the policy. If the information in this application or any attachment materially changes between the date this application is signed and the effective date of the policy, the Applicant will promptly notify the underwriting manager, Company and/or affiliates thereof, who may modify or withdraw any outstanding quotation or agreement to bind coverage.

WARRANTY

I warrant to the Company, that I understand and accept the notice stated above and that the information contained herein is true and that it shall be the basis of the policy and deemed incorporated therein, should the Company evidence its acceptance of this application by issuance of a policy. I authorize the release of claim information from any prior insurer to the underwriting manager, Company and/or affiliates thereof.

Must be signed by the Applicant within 60 days of the proposed effective date.

_____ _____

Name of Applicant **Title**

_____ _____

Signature of Applicant **Date**