National Speech & Language Council
Membership Application

Contact and Practice Information

Full Name (First, Middle, Last) | Practice / Clinic Name

Office Address (include Suite #) | City | State | Zip

Mailing Address – If Different from Office Address | City | State | Zip

Office Phone | Alternate Phone (Home, Cell, etc.) | Fax | Email

SLP License Number(s) | State Issued | Date Issued | SLP College and Location | Year Graduated

Social Security Number | Birth Date | Sex: ❒ Male ❒ Female

Professional Information

1. 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
2. Has any agency or association ever investigated or taken any action against you or your license/certification? (If *YES*, explain) ❒ Yes ❒ No
3. Have you ever had liability insurance refused, declined, canceled, or accepted on special terms? (If *YES*, explain) ❒ Yes ❒ No
4. Have you ever used any drug or substance that interfered with your ability to perform SLP duties? (If *YES*, explain) ❒ Yes ❒ No
5. 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
6. Do you ever provide SLP services to a professional athlete? (If *YES*, explain) ❒ Yes ❒ No
7. Do you use any technique or therapy other than as taught in the SLP schools and colleges? (If *YES*, explain) ❒ Yes ❒ No
8. Do you ever collect fees before the day on which you render treatment? (If *YES*, attach explanation) ❒ Yes ❒ No
9. Have you (or has a collection agency on your behalf) ever sued a patient to collect fees? (If *YES*, attach explanation) ❒ Yes ❒ No
10. Do you always record the patient's account of his progress, objective findings, and details of treatment procedures? ❒ Yes ❒ No
11. Do you refer to other health providers? ❒ Yes ❒ No *If YES*, circle: MD Ortho Neuro DC LAc RN RPT Other
12. Do you treat Medicaid patients? ❒ Yes ❒ No *If YES*, what % of your practice is Medicaid / Medi-Cal?
13. When do you want your SLP malpractice insurance to be in effect? (may not be before date app is received)
14. List other health professions you are licensed to practice (RN, MD, DO, etc.)
15. Who provides your malpractice insurance for that profession? Policy Expires:
16. Complete the following to extend coverage to an Additional Insured with either Shared Limits or Separate Limits (charges apply as indicated):

❒ Shared Limits: Your own Professional Corp or Professional Partnership: Free | Any other entity (Landlord, Management Co., etc.): $10 / Entity

❒ Separate Limits: Any entity with Separate Limits, regardless of ownership: $40 / Entity (Add sheets if needed)

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Professional Liability Coverage

$1,000,000 Per Occurrence / $3,000,000 Aggregate

Payment

Membership and Coverage	$129.00
Additional Insured (Ref. Question 16)	
General Liability @ $50	
Business Personal Property @ $103.20 (Lloyd's of London · $10K Limit · Incl. Tax)	
Total Payment Remitted	

Pmt Type: ❒ Check ❒ MasterCard ❒ Visa ❒ AMEX

Card #: _____ Exp: _____

Fax or Mail Application To:

National Speech & Language Council
1100 W. Town and Country Rd., Ste. 1400
Orange, CA 92868

P: 800-860-8330 F: 714-571-1863

Agreement & Signature

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 of, or 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.

APPLICATION/DUTY TO REPORT INCIDENTS: I hereby apply for coverage. If provided, charge my credit card for the amount indicated. I understand that there is no guarantee that coverage will be issued or 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:** _____