PT[1] Platinum Application

NOTE: SUPPLEMENT MUST BE DATED AND SIGNED BY OWNER, PARTNER, OFFICER OR ADMINISTRATOR. PLEASE TYPE OR PRINT IN INK.

1. Applicant Name (including DBA's): ______________________
   FEIN or Social Security Number: ______________________
   Mailing Address: ______________________
   Location Address(es): ______________________
   ____
   County (parish) of each location: ______________________
   Telephone Number: Office ______/______________ Fax ______/______________
   Person to contact for survey: Name ______________________
   Title ______________________
   Email Address ______________________

2. Number of estimated client contacts Next 12 months: ______________ Last 12 months: ______________
   Annual Gross Receipts: Estimated next 12 months - $ ______________
   Last 12 months - $ ______________
   Total Annual Payroll: Estimated next 12 months - $ ______________
   Last 12 months - $ ______________

3. Entity is ❑ Individual ❑ Corporation
   ❑ Partnership ❑ Professional Association/Corporation
   ❑ Other (Describe) ______________________
   Year entity established: ______________________
   Are you affiliated with a national or regional network or association? ❑ Yes ❑ No
   If yes, please indicate all applicable in order to verify eligible programs. ______________________
   ____
   Please describe in detail any additional operations, business pursuits, joint ventures in which your facility is currently engaged that would fall outside the scope of typical physical therapy operations. ❑ None If yes, describe ______________
   ____

4. How many years have you been under the same ownership? ______________________

5. How many years of experience do you have in the rehab industry? ______________________

6. Indicate each treatment modality used by the applicant.
   _____ Short Wave Diathermy _____ Ultrasound
   _____ Electrical Stimulation _____ Mechanical Traction
   _____ Galvanic _____ Whirlpool
   _____ Ultraviolet _____ Other (describe) ______________________
   _____ Mobile Equipment (describe) ______________________

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7. Do you maintain records that indicate the total number of clients seen by each therapist, aide and assistant? ❑ Yes ❑ No

8. Does any one therapist, aide or assistant represent 25% or more of your total revenue? ❑ Yes ❑ No

9. Are employees that lift clients or assist clients in weight-bearing movements required to wear back support? ❑ Yes ❑ No

10. Do you have procedures in place for the handling of your larger clients? ❑ Yes ❑ No

11. Do you require any employee who is injured while providing your services to clients to go to the emergency room or their own primary care physician? ❑ Yes ❑ No

12. Do you require an official release from the emergency room or PCP prior to the employee returning to work? ❑ Yes ❑ No

13. If the injured employee cannot return to work immediately, do you hire temporary workers to replace him/her? ❑ Yes ❑ No

14. Is it your intent, in the absence of a key member of your staff, to maintain the same client base and not to reduce the annual number of clients seen? ❑ Yes ❑ No

15. Do you provide physical therapy services only as prescribed by a physician? ❑ Yes ❑ No
IF NO, explain exceptions. ____

16. Do you keep daily work reports on all patients as they are seen? ❑ Yes ❑ No

17. Approximately what percentage of your patients are: a) under the age of 18? _______%
b) over the age of 18 ? _______%

18. Approximately what percentage of your practice is associated with sports injuries? _______%
Have you treated any professional or collegiate athletes? ❑ Yes ❑ No
IF YES, how many in the past year? ____

19. Are any tests conducted/results interpreted or diagnosed by you? ❑ Yes ❑ No
IF YES, describe including who the results are sent to and on whose letterhead results are shown. ____________________
____
____
____

20. How many employees/independent contractors do you employ in each of the following positions:
Physical Therapists ____________ Physical Therapy Assistants ____________
Occupational Therapists________ Speech Therapists____________________
Massage Therapists____________ Physician/Physician Assistants__________
All others (describe)____

21. How many employees drive their personal auto in connection with your business? ______________________
How many of these are part-time employees? 15-25 hrs wk ____________ Under 15 hrs wk ______________
If persons other than employees use their personal auto in connection with your business, please describe and give number: ______________________
Do you check all driver's MVRs? ❑ Yes ❑ No
Do you require drivers to carry auto insurance with limits as required by state law? ❑ Yes ❑ No
Do you have owned, leased or hired autos used in business? ❑ Yes ❑ No
Insurance coverage: carrier ______________ limits ____________effective date___________
Have any auto claims been made or occurrences reported during the past 5 years? ❑ Yes ❑ No
If yes, describe, indicate open/closed status, amounts paid or reserved: ______________________

22. What operating system, e.g., -Windows 7, 8, etc., do you use? ______________________

23. How often do you perform system updates? ______________________

24. Do you use firewall technology? ❑ Yes ❑ No

25. Do you use anti-virus software? ❑ Yes ❑ No
If yes, is anti-virus software installed on all of your employees (used for business) computer systems, including laptops, personal computers and networks? ❑ Yes ❑ No

26. Do you use intrusion detection software to detect unauthorized access to internal networks and computer systems? ❑ Yes ❑ No

27. Is it your policy to upgrade all security software as new releases or improvements become available?
❑ Yes ❑ No

28. Do you provide remote access to its network? ❑ Yes ❑ No
Is remote access restricted to Virtual Private Networks (VPNs)? ❑ Yes ❑ No

29. Do you have written screening and hiring policies and procedures for all prospective employees, students, independent contractors/consultants and volunteers? ❑ Yes ❑ No
Are there written guidelines regarding sexual misconduct or physical abuse? ❑ Yes ❑ No
Do you perform criminal background checks as part of your employee screening process? ❑ Yes ❑ No
Have you had any incidents or claims reported for sexual misconduct or any other allegation of abuse? ❑ Yes ❑ No
If yes, provide full details. ______________________
Have you or any of your employees:
a) Ever been the subject of disciplinary or investigatory proceedings or reprimanded by an administrative or governmental agency, hospital or professional association? ❑ Yes ❑ No
b) Had any professional license refused, suspended, revoked, renewal refused or accepted only with special terms or have you or any of your employees voluntarily surrendered any professional license? ❑ Yes ❑ No
c) Been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ❑ Yes ❑ No

30. Do you have a formal risk management procedure in place? ❑ Yes ❑ No
If yes, who is responsible and what is his/her job title? ______________________
IF THE ANSWER TO ANY OF THE ABOVE IS YES, PLEASE ATTACH A DETAILED EXPLANATION.

31. Have any claims been made or occurrences reported during the past five years against any of the proposed insureds or against any entity in which any proposed insured has or has had an interest?

❑ Yes ❑ No If yes, please describe, indicate status of the claim or suit, and any amount(s) paid or reserved *(attach an additional sheet if necessary).*

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32. Does any proposed insured have any knowledge of an event, circumstance or occurrence (other than any listed in #31 above) prior to the effective date of the proposed policy, or does any proposed insured foresee that a claim may be brought as a result of said event, circumstance or occurrence?

❑ Yes ❑ No If yes, describe the event and indicate the reason for anticipation of a claim.

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33. Do you require all insured's, including employees and contractors, to report ALL incidents to the Named Insured no later than the end of the workday on which the incident occurred? ❑ Yes ❑ No

I understand and agree this application and any and all supplements attached hereto may be made a part of any policy issued, and any such policy will be issued in reliance upon the representation made herein. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the Company, result in the voiding of insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to the company providing insurance coverage and VGM Group, Inc. any documents, records or other information bearing upon the foregoing.

I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Applicant and all owners, employees, and contractors are licensed or duly authorized in all states or jurisdictions where professional services are provided. Applicant warrants the truth of all answers to the above questions, and that applicant has not withheld any information that is calculated to influence the judgment of the insurance company in considering this application. **IMPORTANT: THIS APPLICATION MUST BE SIGNED BY THE APPLICANT. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE.**

____________________ ____

Date Applicant / Title