



# HOLISTIC HEALTH PRACTITIONER 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 \_\_\_\_\_

Practitioner \_\_\_\_\_  
 Holistic Health School Attended (Students provide School attending and expected completion info) \_\_\_\_\_ Graduated \_\_\_\_\_ Hours Completed \_\_\_\_\_

Student \_\_\_\_\_

## PROFESSIONAL INFORMATION (Students Skip to Question 11)

1. What current Holistic Health Professional (HHP) Certification do you hold?  AINM  Other \_\_\_\_\_  None
2. Has any malpractice claim or proceeding ever been brought against you, your associates or employees, or are you aware of any circumstance that could give rise to such a claim? (If YES, attach explanation)  Yes  No
3. Has any agency or association investigated or taken any other action against 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 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. Do you provide any service or advice other than as taught in the HHP schools and colleges? (If YES, explain)  Yes  No
10. Do you currently carry HHP Liability insurance?  Yes  No If YES, Carrier: \_\_\_\_\_ Policy Expires \_\_\_\_\_
11. List other health professions you are licensed to practice (RN, LMT, LAc, etc.) \_\_\_\_\_
12. Who provides your malpractice insurance for that profession? \_\_\_\_\_ Policy Expires: \_\_\_\_\_
13. When do you want your Holistic Health insurance to be in effect (may not be before date app is received)? \_\_\_\_\_
14. List any entity you want as an additional insured (cost is \$25 /entity): \_\_\_\_\_

## MEMBERSHIP OPTIONS AND PAYMENT

Professional & Student Membership includes \$1 million / \$3 million Professional & Premises Liability Coverage. Fellowship & Affiliate categories do not include coverage. Check the following box  if you do not want \$10 of your Membership to go to the AINM Pac.

- |  |            |       |
|--|------------|-------|
| <input type="checkbox"/> Professional          | @ \$ 535 = | _____ |
| <input type="checkbox"/> Student               | @ \$ 199 = | _____ |
| <input type="checkbox"/> Fellowship            | @ \$ 100 = | _____ |
| <input type="checkbox"/> Association Affiliate | @ \$ 50 =  | _____ |
| <input type="checkbox"/> Additional Insured    | @ \$ 25 =  | _____ |

### TOTAL AMOUNT DUE:

- Check  MasterCard  Visa  Discover  AMEX
- Card #: \_\_\_\_\_ Expires: \_\_\_\_\_

## SIGN THEN FAX OR MAIL APPLICATION

I hereby apply for membership and / or coverage. I declare that the above statements are true and I have not suppressed or misstated any facts. I agree that this declaration shall be a basis for, and form a part of, my professional liability policy and my AINM membership. I understand untrue statements could void my policy and / or my AINM membership. I understand that, I have a 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. I understand that Returned checks will be charged a \$35.00 administrative fee.

SIGN: \_\_\_\_\_ DATE: \_\_\_\_\_

REMIT TO: **AHS** (American Health Source)  
 801 W. NORTON AVE, SUITE 420 MUSKEGON MI 49441  
 888-375-7245 - PHONE 231-733-0746 - FAX