



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 _____
 Student _____

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

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 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
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. Your HHP liability insurance, if approved, will be effective the date your app is received. For a later date, specify here: _____
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. Professional category does not include insurance coverage.

Professional @ \$535 = _____

Professional - No Insurance @ \$100 = _____

Additional Profession @ \$50 = _____

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. If provided, charge my credit card for the amount indicated. I hereby declare that the above statements are true, and I have not suppressed or misstated 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 professional liability policy and 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)
 2040 RAYBROOK SE, SUITE 103 GRAND RAPIDS MI 49546
 888-375-7245 - PHONE 616-575-9066 - FAX