



SUPPLEMENTAL MENTAL AND PHYSICAL HEALTH RELATED INDIVIDUALS AND AGENCIES INCLUDING COUNSELORS APPLICATION

1. Applicant's Name: _____
2. List full names of all individuals or partners and their interests.

3. Applicant's Professional Specialty _____

4. Is applicant in private practice? _____ or an employee? _____

5. Indicate the percent of time spent in the following work locations:

_____ % Administrative Office	_____ % Laboratory
_____ % Classroom	_____ % Patient's Home
_____ % Hospital (be specific)	_____ % Professional Office
_____ % Other (be specific)	_____ % Operating Room
_____ % Other (be specific)	_____ % Outpatient Clinic

6. Please check the type of service provided:

_____ Aide or Assistant	_____ Nutrition – Diets
_____ Audiology	_____ Private Counseling
_____ Contact Lens Technician-Optician	_____ Psychology (Private Practice Only)
_____ Dental Hygiene	_____ Social Work
_____ External Prosthetic Device	_____ Swimming Instructor
_____ Guidance	_____ Therapy (Occupational, Physical, Respiratory, Speech)
_____ Home Health Care	_____ Other (be specific)
_____ Hospice	_____
_____ Marriage	_____
_____ Minister, Rabbi, Priest	_____
_____ Non-Profit Counseling (be specific) _____	
_____ Non-Profit Referral Only – Hotlines (be specific) _____	

7. Indicate the number of:

Receipts	_____
Outpatient Visits	_____
Individual Professional Employees	_____

Payroll _____

Participants _____

Other (be specific) _____

8. List any professional association in which applicant is a member:

Describe any professional training, licensing or certification needed for this operation: _____

9. If you are an employee, please advise if you have any management or supervisory duties. _____

If so, what are they? _____

10. Do you administer any anesthesia? _____ Yes _____ No

11. If you contract your services to others on an independent contractor basis, please advise to whom you contract your work? _____

COVERAGE IS NOT BINDING UNTIL APPROVED BY THE COMPANY.

Applicant's Signature _____

Date: _____