National Dietetic Council
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 _____

Dietician License # _____ State Issued _____ Date Issued _____ Dietician School Attended _____ Graduated On _____ Hours Training _____

Professional Information

1. Is your Dietician license issued by: ❒ State ❒ City ❒ N/A Is your Dietician license current? (Attach Copy) ❒ Yes ❒ No
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 license / 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 Dietician duties? (If *YES*, explain) ❒ Yes ❒ No
6. 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
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 Dietician services to a professional athlete? (If *YES*, explain) ❒ Yes ❒ No
9. Do you provide any services other than dietetic advice and supplements to promote general health? (If *YES*, attach explanation) ❒ Yes ❒ No
10. Do you provide any service or advice other than as taught in the Dietician schools and colleges? (If *YES*, explain) ❒ Yes ❒ No
11. List any other health designation you hold (RN, LMT, etc.) _____ Do you separately cover these for malpractice? ❒ Yes ❒ No
12. Who provides your current dietician malpractice coverage? _____ Policy Expires _____
13. To add Premises Liability ($50 / location), list address here: _____
14. List any entity you want as an additional insured *(cost is $10 / entity)*: _____
15. Your Dietician liability insurance, if approved, will be effective the date your app is received. For a later date, specify here: _____

Payment

Membership and Coverage	$89.00
Additional Insured @ $10 / Entity	
Premises Liability @ $50 / Location	
Total Payment Remitted	

Pmt Type: ❒ Check ❒ MasterCard ❒ Visa ❒ AMEX

Card #: _____ Exp: _____

Fax or Mail Completed Application To:

National Dietetic Council
1100 W. Town and Country Road, Suite 1400
Orange, CA 92868
800-860-8330 Phone 714-571-1863 Fax

Agreement & Signature

$1,000,000 / $3,000,000 Professional Liability Coverage

NO FALSE STATEMENTS: I hereby apply for coverage. If provided, charge my credit card for the amount indicated. I hereby declare that the above statements are true, and I have not misstated or suppressed any facts. I agree and understand that this 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 or of 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.

RENEWAL APPLICATION/DUTY TO REPORT INCIDENTS: I understand that there is no guarantee that coverage will be 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:** _____