AMC Skin Care 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 ____

Skin Care License / Certification # ____ Issued By: ❑ State ❑ City ____ Date Issued ____ Skin Care School Attended ____ Graduated On ____ Hrs. Training

Professional Information

1. Do you hold a current skin care license / certification as required in the state where you practice? (If *YES*, 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 board, agency, association, or insurer investigated or taken any action involving you or your license? (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 skin care 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. Do you diagnose or treat any skin disease, injury, or disorder? (If *YES*, explain) ❑ Yes ❑ No
9. Are you providing any skin care service that was not a part of your skin care training program? (If *YES*, explain) ❑ Yes ❑ No
10. Check to indicate if you provide any of the following services (a separate application addendum is required):

❑ Black Henna	❑ Laser	❑ Peels & Chemicals	❑ Tattoo / Permanent Makeup
❑ Cosmetology	❑ LED / Micro-current	❑ Piercing, Branding, Scarification	❑ Teeth Whitening
❑ IPL	❑ Massage	❑ Tanning Booths	❑ Whirlpool

11. Do you hold any other health designation (RN, L.Ac, etc.)? ❑ Yes ❑ No If *YES*, list here: ____ (Separate coverage is required)
12. Who provides your current skin care malpractice coverage? ____ Policy Expires: ____
13. To add Premises Liability *($50 / location)*, list address(es) here: ____
14. List any entity you want as an additional insured *($10 / entity)*: ____
15. Your skin care insurance, if approved, will be effective the date your app. is received. For a later date, specify here: ____

Payment

Membership and Coverage		$129.00
Additional Insured	@ $ 10.00 =	
Premises Liability	@ $ 50.00 =	
Business Personal Property ($10,000 Limit – Thru Lloyd's of London – Incl. Tax)	@ $103.20 =	
Total Payment Remitted		

Pmt Type: ❑ Check ❑ MasterCard ❑ Visa ❑ AMEX

Card #: ____ Exp: ____

Fax or Mail Completed Application To:

AMC Skin Care Council
1100 W. Town & Country Rd., Ste. 1400
Orange, CA 92868
800-500-3930 Phone 714-571-1863 Fax

Agreement & Signature

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

NO FALSE STATEMENTS: I hereby declare that the above statements are true, and I have not misstated or suppressed 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 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:** ____

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