



CARRIER:

United States Liability Insurance Company

Allied Health Care Product – Miscellaneous Classes

Complete the following only for the professions for which you are applying for coverage. Professions not listed here may require a separate supplemental application.

1. Name of applicant: _____

A. Dental Assistant

2. Does the applicant work under a dentist's supervision? Yes No
3. Does the applicant administer any form of anesthesia (including local, general or sedation)? Yes No

B. Dental Hygienist

4. Does the applicant work under a dentist's supervision? Yes No
5. Does the applicant administer general or sedative anesthesia? (Do not answer "Yes" if local anesthesia only.) Yes No

C. EEG Technician/Technologist

6. Is the applicant CPR certified, or do they have CPR-certified staff on duty? Yes No
7. What percentage of services involve pediatric patients? _____ %

D. First Aid/CPR Training

8. Does the applicant provide services creating evacuation plans or compliance with fire/safety regulations? Yes No
9. Does the applicant provide training other than first aid/CPR? Yes No
10. Does the applicant specialize in consulting services for earthquakes, terrorism, weapons of mass destruction or similar catastrophic events? Yes No

E. Health Educator

11. Does the applicant provide abortion counseling, adoption screening or foster care screening? Yes No
12. Does the applicant specialize in emergency preparedness or catastrophic/mass-epidemic consulting? Yes No

F. Lactation Consultant

13. Does the applicant specialize in consulting for premature infants? Yes No

G. Medical Office Assistant

14. Does the applicant provide services as a physicians assistant? Yes No
15. Is the applicant involved in utilization review, peer review/case management services or making managed care treatment decisions? Yes No
16. Does the applicant provide clinical services including medical treatment, prepare/administer medication, remove sutures or assist in physical exams? Yes No

H. Opticians and Optometric Assistants

17. Does the applicant provide any services as an ophthalmologist or optometrist? Yes No
18. Does the applicant fit prosthetic ocular devices? Yes No

I. Patient Intake Technician

19. Does the applicant provide peer review/case management services, make managed care treatment decisions or provide utilization review services? Yes No
20. Does the applicant work in an emergency room? Yes No

J. Speech Language Pathologist

21. Does the applicant perform suctioning or emergency procedures? Yes No

This supplemental application is incorporated into and is deemed a part of the other application(s) submitted in connection with the requested insurance. Any and all notices and representations included in such other application(s) are incorporated by reference in this supplemental application as though fully set forth herein.

Applicant's signature _____ Title _____ Date: _____
(Principal, Partner or Officer)

Print name _____

Agent's signature: _____
(Required in Prince Edward Island and Saskatchewan)