



# Additional Profession Addendum Yoga

## Florida State Massage Therapy Association

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### Complete Addendum Questions & Sign

1. Is your Yoga certification current  Yes  No
2. Has any agency or association investigated or taken action against you or your Yoga certification? (If Yes, explain)  Yes  No
3. Has any malpractice allegation 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
4. Have you ever been convicted of violating any law other than a minor traffic offense? (If Yes, explain)  Yes  No
5. Have you ever used drugs or alcohol that has interfered with performing your professional duties? (If Yes, explain)  Yes  No
6. Do you treat cancer, epilepsy, practice obstetrics, do a differential diagnosis, or do colonics? (If Yes, explain)  Yes  No
7. Have you (or has a collection agency on your behalf) sued a client to collect fees? (If Yes, explain)  Yes  No
8. Are you using any Yoga modality that was not a part of your Yoga school training program? (If Yes, explain)  Yes  No
9. Have you ever provided Yoga services for a professional athlete? (If Yes, explain)  Yes  No
10. Do you hold any other health designation (RN, L.Ac, etc.)?  Yes  No If Yes, list: \_\_\_\_\_
11. Please provide your current Email address: \_\_\_\_\_
12. If paying by credit card, please provide: \_\_\_\_\_  

Card # (MasterCard, Visa or Amex only)
Expiration Date

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. I understand that there is no guarantee that coverage will be renewed. I also understand that any price distinctions based on safe practices may be based in part on information provided by me on future follow-up data sheets or during future pre-arranged office inspections. I understand that if coverage is granted, I shall have the duty to report in writing, within 3 days, or as soon as practicable, incidents reasonably likely to involve this insurance, including oral or written patient complaints, threats or lawsuits.

SIGN \_\_\_\_\_ DATE \_\_\_\_\_