FSMTA Professional Liability Insurance Program
Colon Hydrotherapy Application

FSMTA exclusive package uses an American Massage Council Purchasing Group approved Master Policy.

CONTACT AND PRACTICE INFORMATION:

Full Name (First, Middle, Last) _____ Practice / Clinic Name _____

Office Address (include Suite #) _____ City _____ State _____ Zip _____

Mailing Address – If Different from Office Address _____ City _____ State _____ Zip _____

Office Phone _____ Alternate Phone (Home, Cell, etc.) _____ Fax _____ Email _____

Colon Hydrotherapy License / Certificate _____ State Issued _____ Date Issued _____ Colon Hydrotherapy School/Program _____ Hrs Training _____ Year Graduated _____

Social Security Number _____ Birth Date _____ Sex: ❒Male ❒Female

PROFESSIONAL INFORMATION

1. Is your Colon Hydrotherapist Certificate issued by: ❒ State ❒ City ❒ N/A Is this Certificate 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 ever investigated or taken any action against you or your license / certificate? (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 colonics 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 use colon hydrotherapy to treat any conditions, diseases or injuries, or do you make any diagnoses? (If *Yes*, explain) ❒Yes ❒No
8. Do you provide colonic services to anyone with cancer, hemorrhoids, bloody diarrhea, rectal abnormalities, or who is receiving treatment for their kidneys? (If *Yes*, explain) ❒Yes ❒No
9. Do you ever administer anesthesia or any prescription drug? (If *Yes*, explain) ❒Yes ❒No
10. Do you always require a person to sign an informed consent prior to receiving colonic services? ❒Yes ❒No ❒No, but I will do so now
11. How many colonics clients do you treat / week? _____ How many colonic irrigations or procedures do you perform / week? _____
12. What is the maximum number of times you allow a single person to receive colonic irrigations in any 12 month period? _____
13. Do you ever provide colon hydrotherapy services to minors (persons under the age of 18)? ❒Yes ❒No
14. Do you ever collect fees for services before the day on which you provide those services? (If *Yes*, attach explanation) ❒Yes ❒No
15. Have you, or anyone on your behalf, ever sued a colonics client to collect fees? (If *Yes*, attach explanation) ❒Yes ❒No
16. Equipment - The following are questions about your colon hydrotherapy machine (the "Device"):
    a. Does the Device have its own chemical sanitizing unit? ❒Yes ❒No
    b. Does the Device have its own built-in water purification unit? ❒Yes ❒No
    c. Is the Device approved by the FDA? ❒Yes ❒No If *Yes*, FDA approval number: _____
    d. Does the Device have a disposable colonic reservoir, tube, and xp? ❒Yes ❒No
    e. Does the Device have automatic temperature control with a temperature sensor? ❒Yes ❒No
    f. Does the Device have an automatic back flow prevention sensor and an automatic pressure sensor? ❒Yes ❒No

PROFESSIONAL INFORMATION *(Continued from Page 1)*

17. Techniques / Practice Protocol

a. Do you provide colon hydrotherapy services to persons who are in the seated position? (If *Yes*, explain) ❒Yes ❒No

b. Before providing colon hydrotherapy, do you determine if the person has a history of bloody diarrhea, diverticulitis, colitis, ulcerative colitis, colon cancer, hemorrhoids, bleeding hemorrhoids, rectal fissures / abnormalities, or any kidney condition? ❒Yes ❒No

If *Yes,* will you still provide colon hydrotherapy to a person with a history of one or more such conditions? (If *Yes*, explain) ❒Yes ❒No

c. When providing colon hydrotherapy, do you ever cause anything other than purified water to be put into a person's colon? ❒Yes ❒No

If *Yes*, list any other substances and explain the reason(s) for using each such substance (attach additional sheets if necessary):

Substance Used	Reason for use of substance

18. Training:

a. Are you certified by the International Association for Colon Hydrotherapy? ❒Yes ❒No

b. Have you completed a course of study in colon hydrotherapy that satisfies the requirements of the state licensing board in your state that licenses colon hydrotherapy services? ❒Yes ❒No

If *Yes*: Identify the course of study: _____ List the number of hours that you attended the course: _____

Identify the state licensing board that approves such course: _____

c. Other than what you set forth in Question 18b, have you completed any other courses of study in colon hydrotherapy? ❒Yes ❒No

If *Yes*: Identify the course of study: _____ List the number of hours that you attended the course: _____

19. a. Do you have a website? ❒Yes ❒No If *Yes*, provide web address: _____

b. Do you provide colonic hydrotherapy advice or services on the World Wide Web? ❒Yes ❒No

If *Yes*, please provide details: _____

20. Do you use promotional literature? (If *Yes*, attached a copy) ❒Yes ❒No

21. Which advertising media do you use? ❒Newspaper ❒Direct Mail ❒T.V. ❒Radio ❒None (Check all that apply – Attach copies)

COVERAGE OPTIONS

Select your policy limits (includes both Professional & General liability), Rates quoted do not include FSMTA Membership. Limits chosen follow to additional profession massage coverage.

❒ $1,000,000 / $3,000,000	@ $262 =	
❒ $2,000,000 / $6,000,000	@ $371 =	
❒ Massage Additional Profession	@ $34 =	
❒ Business Personal Property ($10,000 Limit – Issued by Lloyd's of London)	@ $135 =	
TOTAL DUE:		

PAYMENT OPTIONS

❒ Check ❒ Discovery ❒ MasterCard ❒ Visa ❒ AMEX

Card #: _____ Expires: _____

3 or 4 Digit Security Code: _____ Billing Zip Code: _____

SIGN THEN FAX OR MAIL APPLICATION

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 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 this is a Claims Made policy which 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. 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, threats, or filings of lawsuits.

SIGN: _____ DATE: _____

SEND APPLICATION AND REMIT PAYMENT TO:

FSMTA
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Tampa, FL 33624
P: 407.786.3307 F: 813.422.7966
Email: info@fsmta.org - Web: www.fsmta.org