



THIS IS AN APPLICATION FOR PROFESSIONAL LIABILITY COVERAGE WRITTEN ON CLAIMS MADE BASIS AND COMMERCIAL GENERAL LIABILITY COVERAGE WRITTEN ON EITHER A CLAIMS-MADE OR AN OCCURRENCE BASIS. THE CLAIMS MADE COVERAGE IS LIMITED GENERALLY TO LIABILITY FOR CLAIMS FIRST MADE AGAINST AN INSURED WHILE THE COVERAGE IS IN FORCE. PLEASE REVIEW THE POLICY CAREFULLY AND DISCUSS THE POLICY WITH YOUR INSURANCE REPRESENTATIVE. IF A POLICY IS ISSUED, THE APPLICATION WILL BECOME PART OF THE POLICY AS IF PHYSICALLY ATTACHED. THEREFORE, IT IS NECESSARY THAT ALL QUESTION BE ANSWERED ACCURATELY AND COMPLETELY.

Please include the following:

1. Loss History: (supply the following)
 - a. Claims listing of ten years currently valued, including current year, detailed loss information (preferably in electronic form).
Please see ADDENDUM A for the format
 - b. Carrier loss runs to support information in 1.a. above.
 - c. Full details of allegation on all losses paid or outstanding in excess of \$50,000.
2. Most recent accrediting agency (JCAHO, AOA, CARF, etc.) and state licensure report with recommendations and the institution's response to any contingencies. Please provide copy of original report from agency (not the internet summary).
3. Current audited financial statement.
4. Copy of medical staff by-laws.
5. AHA Survey of Hospitals
6. Risk management and quality improvement plan.
7. Copies of contracts with independent physician's groups.
8. All hold harmless agreements.
9. For self-insured programs:
 - a. Copy of trust financial agreement.
 - b. Copy of trust coverage wording.
 - c. Financial statement of trust fund.
 - d. Recent actuarial review supporting the funding of the self-insured retention.
 - e. Description of claims handling – In house, TPA with details on process, case reserve setting and claims handling expertise of people involved.

The requested information is required before a firm quotation can be provided.

Producer Name: _____

Address: _____

Street

City

Telephone #: (____) _____

Please type or print clearly.

- Answer ALL questions completely, leaving no blanks. If any questions, or part thereof, do not apply, print "N/A" in the space.
- If you need more space for your responses, continue on a separate sheet of your letterhead and indicate question number.
- This form must be completed, dated and signed by the CEO, CFO or Risk Manager of the proposed insured.

1. GENERAL INFORMATION

Applicant Name: _____

Business Address:	Street _____	City, State _____	ZIP _____
Mailing Address:	_____	_____	Telephone #: _____
Website (if applicable)	_____	Years in Business:	_____
Key Contact at Insured:	_____	Title _____	
Federal Tax ID:	_____	E-mail address:	_____

APPLICANT IS (Check all that applies):

- | | | | |
|---|--|-------------------------------------|--|
| A. | B. | C. | D. |
| <input type="checkbox"/> Children's Hospital | <input type="checkbox"/> Individual | <input type="checkbox"/> Profit | <input type="checkbox"/> Accredited by JCAHO |
| <input type="checkbox"/> Clinic | <input type="checkbox"/> Partnership | <input type="checkbox"/> Non-Profit | <input type="checkbox"/> Licensed by the state |
| <input type="checkbox"/> Critical Access Hospital | <input type="checkbox"/> Corporation | <input type="checkbox"/> Charitable | <input type="checkbox"/> Accredited by AOA |
| <input type="checkbox"/> General Hospital | <input type="checkbox"/> Joint Venture | <input type="checkbox"/> Government | <input type="checkbox"/> Medicare Approved |
| <input type="checkbox"/> Psychiatric Hospital | | | <input type="checkbox"/> Member of AHA |
| <input type="checkbox"/> Teaching Hospital | | | <input type="checkbox"/> Accredited by CARF |
| <input type="checkbox"/> Surgi-Center | | | <input type="checkbox"/> Other |
| <input type="checkbox"/> Other: | | | |

E. Requested Coverage:

Effective Date: _____

Professional Liability (Claims Made Only):

Limit: \$ _____ per claim \$ _____ aggregate _____ Retroactive Date _____

Deductible: \$25,000 \$50,000 \$100,000 Other _____

General Liability:

Limit: \$ _____ per claim \$ _____ aggregate _____ Retroactive Date _____

Occurrence Claims-Made
 Deductible: \$10,000 \$25,000 \$50,000 \$100,000 Other _____

Employee Benefits Liability (Claims Made Only):

Limit: \$ _____ per claim \$ _____ aggregate _____ Retroactive Date
 Deductible: \$1,000 \$2,500 \$5,000 \$10,000 Other _____

F. Self-Insured Retention (if applicable):

1. To what line of coverage will a self-insured retention apply? _____
2. What limit of liability for the self-insured retention?
 \$ _____ per claim \$ _____ aggregate
3. Are loss adjustment expenses part of or outside the SIR limit? Yes No
4. Is there a dedicated trust? Yes No
 If No, how is SIR secured? _____
 If Yes, what financial institution manages the trust? _____
 What organization handles claims for the SIR? _____
5. Has an independent actuarial review been completed? Yes No
 Valuation Date of Loss Data Used _____

G. Prior Insurance History

Most recent five (5) Years: (separate Primary General Liability, Professional and Excess/Umbrella, if applicable).

Primary Coverage

Policy Period	Carrier	Limits (HPL/GL)	Deductible (HPL/GL)	Total Premium	Claims Made or Occurrence	Retro Date
		HPL				
		GL				
		HPL				
		GL				
		HPL				
		GL				
		HPL				
		GL				
		HPL				
		GL				

Excess/Umbrella Coverage

Policy Period	Carrier	Limits (HPL/GL)	Deductible (HPL/GL)	Total Premium	Claims Made or Occurrence	Retro Date
		HPL				
		GL				
		HPL				
		GL				
		HPL				
		GL				

		HPL				
		GL				
		HPL				
		GL				

H. Is the applicant operating under a management agreement? If so, please provide details on a separate sheet of paper.

II. EXPOSURE DATA

A. Professional Liability Exposures

	Next 12 Months Projected	Current Year	1 st Year Prior	2 nd Year Prior	3 rd Year Prior	4 th Year Prior	5 th Year Prior
# Licensed Beds (not rated)							
# Occupied Beds							
Acute Care Beds							
Bassinets							
Long Term Care Beds							
Rehab Beds							
Psychiatric Beds							
Chemical Dependency Beds							
# Visits (Outpatient)							
ER Visits							
Other Outpatient Visits							
Psychiatric Visits							
Home Health Visits							
# Procedures							
Inpatient Surgeries							
Outpatient Surgeries							
Deliveries							
Employed Mid-level Practitioners							
Physician Assistant							
Nurse Practitioner							
Nurse Midwife							
CRNA							
# Employed Physicians							
# Employed Residents							

Have there been any material changes in exposures during the last 10 years not reflected above? If so, please provide details.

B. Facilities and Services (check all that apply)

<input type="checkbox"/>	Abortion Clinic	<input type="checkbox"/>	Gift Shop	<input type="checkbox"/>	Outpatient Clinic
<input type="checkbox"/>	Ambulance	<input type="checkbox"/>	Home Health	<input type="checkbox"/>	Pathology
<input type="checkbox"/>	Bariatrics	<input type="checkbox"/>	Hospice	<input type="checkbox"/>	Pharmacy
<input type="checkbox"/>	Blood Bank	<input type="checkbox"/>	ICU	<input type="checkbox"/>	Physical Therapy
<input type="checkbox"/>	Burn Unit	<input type="checkbox"/>	Inhalation Therapy	<input type="checkbox"/>	Radiation Therapy
<input type="checkbox"/>	CCU	<input type="checkbox"/>	Long Term Care	<input type="checkbox"/>	Radiology
<input type="checkbox"/>	Cardiac Catheterization Center	<input type="checkbox"/>	Morgue	<input type="checkbox"/>	Restaurant
<input type="checkbox"/>	Coronary Care Unit	<input type="checkbox"/>	Neurosurgery	<input type="checkbox"/>	Sex Change Surgery
<input type="checkbox"/>	Day Care - Adult	<input type="checkbox"/>	Nursery	<input type="checkbox"/>	Swimming Pool
<input type="checkbox"/>	Day Care - Pediatrics	<input type="checkbox"/>	OB/GYN	<input type="checkbox"/>	Swing Beds
<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	Open Heart	<input type="checkbox"/>	Trauma Center
<input type="checkbox"/>	Dietary	<input type="checkbox"/>	Off-site Birthing Center	<input type="checkbox"/>	Urgent Care Centers
<input type="checkbox"/>	DME	<input type="checkbox"/>	Operating Rooms	<input type="checkbox"/>	X-ray
<input type="checkbox"/>	Emergency	<input type="checkbox"/>	Organ Transplants	<input type="checkbox"/>	Other
<input type="checkbox"/>	Experimental Surgery	<input type="checkbox"/>	Outpatient Surgi-centers	<input type="checkbox"/>	Other

C. Other Special Activities

- Clinical Research
- Experimental Drugs Administration
- Biomedical device research and development.
- Animal research.
- Clinical site for students (specify all that apply)

Please provide details if any of the above apply:

D. Health care Professionals

1. Professional Employees: (indicate total number of employees in each category)

<u>Position</u>	<u>Full-Time</u>	<u>Total Full-Time Equivalents</u>
Employed physicians	_____	_____
Employed surgeons	_____	_____
Interns	_____	_____
Residents	_____	_____
Dentists	_____	_____
Podiatrists	_____	_____
Physician Assistants/Nurse Practitioners	_____	_____
Midwives	_____	_____
Registered nurses	_____	_____
LPNs	_____	_____
Student nurses	_____	_____
X-Ray technicians	_____	_____
Lab technicians	_____	_____
Pharmacists	_____	_____

Profusionists	_____	_____
EMT's/Paramedics	_____	_____
CRNAs	_____	_____
Other employees	_____	_____
Volunteers	_____	_____

2. Nurse Staffing

What was the average RN vacancy for the past 12 months? _____ %

What percent of nursing shifts per month were staffed by agency personnel (avg. last 12 months) _____ %

2. Employed Physicians to be included for coverage:

Number	Physician Name	# Years in Practice	Full Time Equivalent	Retroactive Date	Date Hired	Termination/End Date	Coverage Type Claims Made or Occurrence	American Board Certified or Eligible (Y/N)	Specialty*	Surgery - None, Minor or Major
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
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18										
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21										
22										
23										
24										
25										

* If specialty is Family Practice, please indicate with or without OB.

- If yes, what are limits required? _____ per claim _____ aggregate
- f. Are all privileges granted to staff doctors detailed in writing? Yes or No
- g. Has the license of any staff physician ever been restricted or suspended? Yes or No
- If yes, please provide details: _____

6. Anesthesiology

- a. Is anesthesiology department staffed by: # of each
- | | | |
|-------|---------------------|-------|
| _____ | Employed Physicians | _____ |
| _____ | Contract Group | _____ |
| _____ | Employed CRNAs | _____ |
| _____ | Staff Physicians | _____ |
| _____ | Staff CRNAs | _____ |
- b. If under contract, name of group: _____
 If contract group, are certificates of insurance required? Yes or No
 If yes, what are limits required? _____ per claim _____ aggregate
- c. Are all anesthesiologists required to be board certified or eligible in Anesthesiology? Yes or No
- d. Is the anesthesia care performed by CRNAs supervised and reviewed by the anesthesiologists? Yes or No
 If no, please explain: _____
- e. Do any of the anesthesia services staff routinely work more than a 12-hour duty shift? Yes or No
 If yes, please explain: _____

7. Radiology

- a. Is radiology department staffed by: # of each
- | | | |
|-------|---------------------|-------|
| _____ | Employed Physicians | _____ |
| _____ | Contract Group | _____ |
| _____ | Staff Physicians | _____ |
- b. If under contract, name of group: _____
 If contract group, are certificates of insurance required? Yes or No
 If yes, what limits are required? _____ per claim _____ aggregate
- c. Are all radiologists required to be Board Certified or eligible in Radiology and/or Nuclear Medicine? Yes or No

8. Emergency Department

- a. How is emergency department classified according to JCAHO standards:
- Level I (tertiary) _____ Level II (comprehensive) _____ Trauma Center _____
 Level III (basic) _____ Other _____
 N/A _____

- b. Is emergency department staffed by: # of each
 _____ Employed Physicians _____
 _____ Contract Group _____
 _____ Rotating Staff _____
- c. If under contract, name of group: _____
 If contract group, are certificates of insurance required? Yes or No
 If yes, what are limits required? _____ per claim _____ aggregate
- d. Are all physicians board certified or eligible in emergency medicine? Yes or No
 If No, are they ACLS or PALS certified? Yes or No
- e. Are the emergency physicians required to respond to cardiac/respiratory arrests or other medical emergencies occurring in the institution? Yes or No
- f. Is the emergency room equipped with the following:
 Emergency resuscitation care equipped with defibrillator? Yes or No
 Electrocardiograph machine Yes or No
 Dedicated triage area and staff Yes or No
 Dedicated trauma room(s) Yes or No
- g. Is the Emergency Room open and staffed by a physician 24 hours/day, 7 days/week? Yes or No
- h. Do any of the emergency department staff routinely work more than a 12-hour duty shift? Yes or No
 If yes, please explain: _____
9. Obstetrics: Do you have any OB exposure? Yes or No
 If an OB exposure exists, please complete ADDENDUM B attached.
10. Pharmacy
- a. Does the facility utilize the unit dose system of dispensing medicine? Yes or No
- b. Is a Pyxis or other dispensing system used? Yes or No
- c. Is the pharmacy for patient use only? Yes or No
 If no, annual receipts for nonpatients medications are \$ _____
- d. Is the pharmacy staffed by a contract group? Yes or No
 If yes, please explain: _____

E. Commercial General Liability Exposure

1.a (Attach separate sheet if needed)

Location	Area	Age	Type of Construction	# of Floors	Type of Fire Protection (City, State)
Patient Care Buildings					
Other Buildings					
Parking Lots					

Vacant Lots					
Fire Protection Key: AS = Approved sprinkler; S = Smoke detector; H = Heat detector A = Automatic Alarm					

b. Are all overnight care buildings Fire Resistive and Sprinklered? Yes or No
 If not, explain _____

2. Employee Benefits Liability Exposures

a. Number of Employees? _____
 b. Is Employee benefits Self Administered? Yes or No

3. Other Exposures

a. Has the hospital planned any new construction and/or abatement for this year? Yes or No
 If yes, please provide details: _____

b. Are there elevators or escalators on any premises owned, leased or occupied by the insured? Yes or No
 If so, how many? _____

c. Does the hospital have a heliport? Yes or No
 # of landings per year _____

d. List all owned, leased or chartered aircraft: _____

e. Does the hospital have separate insurance coverage for heliport, owned, leased or chartered? Yes or No
 If yes, provide details of coverage for each to include carrier, limits and policy periods.

f. Does the hospital own or operate an ambulance or other emergency use vehicles? Yes or No

g. List the number and type of owned or leased vehicles: _____

h. List all owned, leased and non-owned watercraft: _____

i. If hospital owns or operates a blood bank:
 i. Number of volunteer donations
 ii. Number of paid donations
 iii. Number of pheresis procedures
 iv. Number of outpatient transfusions
 v. Number of therapeutic plasma exchanges

Is coverage desired for blood bank operations? _____

If "yes", please attach testing procedures. _____

If hospital does not own or operate a blood bank, from where is the blood or blood product obtained?

j. If hospital operates a Day Care:
 _____ Number of children per day
 _____ Number of adults per day
 _____ Number of days per week

On hospital premises? Yes or No
 Open to the public? Yes or No

_____ Ratio of caregivers to children

Please describe hiring practices for caregivers _____

- k. Does hospital operate a Dialysis Unit Yes or No
 If yes, number of procedures per year _____

4. Hold Harmless and Indemnification Agreements

- a. Has the hospital agreed to hold harmless or indemnify others under contract? Yes or No
 b. Does the hospital rent or lease any equipment from others? Yes or No
 If a. or b. is yes, please explain: _____

5. Risk Management/Performance

- a. Who coordinates your risk management program?

Name: _____ Title: _____

Telephone: (____) _____ E-mail: _____

- b. Is there a written, risk management program that has been approved by a governing body? Yes or No

- c. Is there a written performance improvement program that has been approved by a governing body? Yes or No

- d. Does the governing body review the effectiveness of the program and approve necessary changes?

- e. Is the risk manager accountable and solely responsible for risk management?

If no, explain other responsibilities: _____

- f. Does the risk management program include the following:

- ___ Occurrence reporting
- ___ Claim management
- ___ Formal link to quality management
- ___ Safety program and safety committee
- ___ Review and participation in medical staff committees
- ___ Contract review and evaluation

III. EXCESS OR UMBRELLA

If interested in Umbrella or Excess coverage, please provide the following information:

Underlying Information:

Coverage	Carrier	Policy Dates	Limit	Policy Number
Automobile				
Employers Liability				
General Liability				
Heliport Liability				
Non-Owned Aircraft Liability				

Please provide loss information for the above if these lines are being requested.

IV. CLAIMS HISTORY

1. Have any claims ever been made against you? Yes or No
If yes, please provide currently valued carrier loss runs

2. Are you aware of any incident, circumstance or loss which has occurred after the proposed retroactive date, which is likely to result in a claim? Yes or No

If yes, please provide details

Have they been reported to your current or previous carrier(s)? Yes or No

Please note that, without prejudice to any other rights of the Underwriter, it is agreed that any claim or related claim, that arises out of any claim, incident, circumstance or loss that is or reasonably should have been disclosed in Questions 1 and 2 is excluded from the proposed coverage.

THE APPLICANT REPRESENTS THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN OMITTED OR MISSTATED. THIS APPLICATION IS MATERIAL TO AND RELIED UPON BY THE COMPANY. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED BEFORE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE HOSPITAL AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE HOSPITAL UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONALEXPOSURES.

NOTICE TO ARKANSAS, MINNESOTA, AND OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD, WHICH IS A CRIME.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICY HOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICY HOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES.

NOTICE TO DISTRICT OF COLUMBIA, MAINE, TENNESSEE, AND VIRGINIA APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY EMPLOYER OR EMPLOYEE, INSURANCE COMPANY, OR SELF-INSURED PROGRAM, FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY

FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA AND NEW MEXICO APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT MAY BE GUILTY OF INSURANCE FRAUD.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR SUCH VIOLATION.

NOTICE TO OKLAHOMA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE TO OREGON AND TEXAS APPLICANTS: ANY PERSON WHO MAKES AN INTENTIONAL MISSTATEMENT THAT IS MATERIAL TO THE RISK MAY BE FOUND GUILTY OF INSURANCE FRAUD BY A COURT OF LAW.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Signature of Applicant: _____

Title: _____

Date: _____

Signature of Producer: _____

License #: _____

Date: _____