



PERSONAL TRAINER 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 _____

Practitioner _____
 Student _____

Personal Trainer School Attended (Students provide School attending & expected completion info) _____ Graduated _____ Hours Completed _____

PROFESSIONAL INFORMATION (Students Skip to Question 11)

1. What current Personal Trainer Certification do you hold? NATE Other _____ None
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 investigated or taken any other action against you or your license / certification? (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 Personal Trainer duties? (If YES, explain) Yes No
6. Have you ever been 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. Have you ever provided Personal Trainer services for a professional athlete? (If YES, explain) Yes No
9. Do you provide any service other than as taught in the Personal Trainer schools and colleges? (If YES, explain) Yes No
10. Do you currently carry Personal Trainer insurance? Yes No If YES, Carrier: _____ Policy Expires _____
11. List other health care licenses you hold (RN, LMT, LAC, etc.) _____ Do you have a separate policy for these? Yes No
12. Your Personal Trainer insurance #, if approved, will be effective the date your app is received. For a later date, specify here: _____
13. Additional Insured - If you have a corporation or a partnership we recommend you add that entity as an additional insured. Your landlord, employer, or school may also require additional insured status. For each additional insured provide the following. Add sheets as needed:

Entity Name _____ Address _____

MEMBERSHIP OPTIONS AND PAYMENT

Professional & Student Membership includes \$1 million / \$3 million Professional & Premises Liability Coverage. Professional category does not include insurance coverage.

| | | |
|--|-----------|-------|
| <input type="checkbox"/> Professional | @ \$299 = | _____ |
| <input type="checkbox"/> Professional - No Insurance | @ \$100 = | _____ |
| <input type="checkbox"/> Additional Profession | @ \$50 = | _____ |
| <input type="checkbox"/> Additional Insured | @ \$25 = | _____ |
| TOTAL AMOUNT DUE: | | _____ |

Check MasterCard Visa Discover AMEX

Card #: _____ Expires: _____

SIGN THEN FAX OR MAIL APPLICATION

I hereby apply for membership and / or coverage. If provided, charge my credit card for the amount indicated. I hereby declare that the above statements are true, and that 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, I have a 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. I understand that Returned checks will be charged a \$35.00 administrative fee.

SIGN: _____ DATE: _____

REMIT TO: **AHS** (American Health Source)
 2040 RAYBROOK SE, SUITE 103 GRAND RAPIDS MI 49546
 888-375-7245 - PHONE 616-575-9066 - FAX