

CHIROPODIST/PODIATRIST SUPPLEMENT
Forming part of the Professional Liability Application

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Name of Applicant

Provide name and location of university where DPM degree obtained:

Are you a member of your provincial College of Chiropractors or equivalent body? Yes No

Number of years of experience excluding medical training _____
Years

Provide estimated gross revenue from foot surgical billings for next fiscal year: _____
Dollar Amount

Are new patients required to provide medical history and information so that you are aware of any potential risk factors? Yes No

Are patients supplied with comprehensive information on treatment procedures and possible risks and side effects? Yes No

Is every patient required to complete and sign a consent form for each treatment / procedure? Yes No

Does the consent form include a statement that the patient understands and accepts the risk? Yes No

How long do you keep your patient's information/documentation on file? _____
Years

Print Name and Title

Signature of Applicant or Authorized Representative

DATE: | D | D | M | M | Y | Y |