

ACUPUNCTURE SUPPLEMENTAL QUESTIONNAIRE

Your Full Name: _____ Policy Number: _____
(Please Print)

Directions: Please complete the following questions regarding your acupuncture practice. If a question does not apply to your practice, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. **Your signature is required on page 2.**

SECTION I: Acupuncture

1. What percentage of your practice is devoted to the performance of acupuncture? _____ %
2. If you are **not** licensed by the acupuncture board within the state in which you practice, please provide proof of your training (e.g., certificate of course completion) and describe the training program below, including the number of hours of training you completed:

3. Do you perform or intend to perform acupuncture as an anesthetic for surgical procedures? Yes No

If yes, please explain:

4. Please identify the conditions for which you use/intend to use acupuncture:

5. Before you perform acupuncture on an individual, do you always:

a. Perform a history and physical on the individual? Yes No

b. Advise the individual of the risks, benefits and alternatives of acupuncture and, either follow-up the conversation by obtaining the individual's written informed consent or document the discussion in the individual's record?

Yes No

If you answered no to question a or b, please explain:

6. If you are a physician, do you employ, independently contract with or otherwise supervise others who perform acupuncture?
 Yes No

If yes, please identify each individual and your professional relationship with him or her:

SECTION II: Remarks

Please provide any additional information to further describe your acupuncture practice that has not otherwise been addressed in this questionnaire:

For California and Rhode Island Physicians and Health Care Providers Only

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my coverage. I agree to notify NORCAL Mutual Insurance Company immediately if my practice changes in any way and of any change in the information contained on this questionnaire.

Signature

Date

Print Name

For Alaska Physicians and Health Care Providers Only

I represent the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my coverage. I agree to notify NORCAL Mutual Insurance Company immediately if my practice changes in any way and of any change in the information contained on this questionnaire.

Signature

Date

Print Name