Missouri Medical Malpractice Joint Underwriting Association

4700 Country Club Drive
Jefferson City, MO 65109
Phone: 573-893-5300
Fax: 573-893-3748

Facility Professional Liability Application

Section I - Facility Information

Name of Applicant and Mailing Address:		
D.B.A.	Name of Parent Company	
Name of Administrator	Name of CFO	
Federal Tax Identification Number	Annual Receipts $	Annual Payroll $

Applicant is: (check all boxes applicable)

A.
- ❑ Children's hospital
- ❑ Geriatric hospital
- ❑ General hospital
- ❑ Psychiatric hospital
- ❑ Rehabilitation hospital
- ❑ Teaching hospital
- ❑ Skilled nursing home
- ❑ Assisted living home
- ❑ Independent Living
- ❑ Residential Care

B.
- ❑ Individual
- ❑ Partnership
- ❑ Corporation
- ❑ Joint venture
- ❑ Government
- ❑ Limited Liability Company

C.
- ❑ Profit
- ❑ Non-profit
- ❑ Charitable

D.
- ❑ Accredited by J.C.A.H.O.
- ❑ Licensed by state
- ❑ Accredited by A.O.A.
- ❑ Medicare approved
- ❑ Member of A.H.A.
- ❑ Accredited by C.A.R.F.

Section II - Facility Locations

Primary Facility Address (Street, City, State, Zip Code)		
County	Primary Practice Phone Number	Primary Practice Fax Number

Secondary Location Address (Street, City, State, Zip Code) Attach Schedule if additional space needed.		
County	Secondary Practice Phone Number	Secondary Practice Fax Number

1. May we communicate with you by fax? ❑ Yes ❑ No
2. May we communicate with you by e-mail? ❑ Yes ❑ No E-Mail Address _____

For Agent's Use Only (If applicable)

Name of Agency: _____ Name of Agent: _____

Address: _____ Phone Number: _____

e-mail Address: _____ Fax Number: _____

Signature: _____ Date: _____

Are you authorized to place casualty insurance under subdivision 1(4) of Section 375.018, RSMo? ❑ Yes ❑ No

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Section III - Coverage Selection

Requested Effective Date of Coverage: _____
Month Day Year

Requested Retroactive Date: _____
Month Day Year

If no Retroactive Date (Prior Acts) is requested, please explain why:

- ❑ Reporting Coverage will be obtained from current claims-made carrier
- ❑ Current coverage is on occurrence form
- ❑ Prior Acts Coverage will not be obtained from the Association or from my current claims-made carrier. I understand that failure to obtain Reporting Coverage will leave me without complete coverage.

Important: Coverage will become effective only after the completion of all underwriting functions, acceptance by the Association, and receipt of payment.

Coverage Type and Limits of Liability (check all that apply)

- ❑ Facility Claims Made Professional Liability Coverage
  $500,000 each medical incident/$1,500,000 annual aggregate
- ❑ Facility Claims Made Professional Liability Coverage
  $1,000,000 each medical incident/$3,000,000 annual aggregate

- ❑ Commercial General Liability Claims Made Coverage
  $500,000 each incident/$1,500,000 general aggregate
- ❑ Commercial General Liability Claims Made Coverage
  $1,000,000 each incident/$3,000,000 general aggregate

(General Liability limits may not exceed Facility Claims Made Professional Liability Coverage limits)

Section IV - Insurance History

Professional Liability:

	Current Coverage	First Year Prior	Second Year Prior	Third Year Prior	Fourth Year Prior
Name of Carrier					
Form of Coverage	❑ Occurrence ❑ Claims-Made	❑ Occurrence ❑ Claims-Made	❑ Occurrence ❑ Claims-Made	❑ Occurrence ❑ Claims-Made	❑ Occurrence ❑ Claims-Made
Effective Date and Expiration Date					
Retroactive Date (NA for occurrence)					
Was Extended Reporting Coverage obtained?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No

General Liability:

	Current Coverage	First Year Prior	Second Year Prior	Third Year Prior	Fourth Year Prior
Name of Carrier					
Form of Coverage	❑ Occurrence ❑ Claims-Made	❑ Occurrence ❑ Claims-Made	❑ Occurrence ❑ Claims-Made	❑ Occurrence ❑ Claims-Made	❑ Occurrence ❑ Claims-Made
Effective Date and Expiration Date					
Limits of Liability					

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1.	Has your facility ever operated without professional liability coverage?	❑ Yes	❑ No
2.	Has your facility ever operated without commercial general liability coverage?	❑ Yes	❑ No
3.	Was your professional liability coverage ever placed with a non-admitted carrier?	❑ Yes	❑ No
4.	If previously insured on a claims-made form, has your facility ever failed to obtain Extended Reporting Coverage?	❑ Yes	❑ No
5.	Do you owe any outstanding premium to any carrier?	❑ Yes	❑ No

If any answer to questions 1 - 5 above is "Yes", please provide dates and explanations below:

Section V - Professional Employees or Contractors

Following is list of professional allied health care providers for which coverage does not extend and a separate policy is required. If coverage is desired, please complete a separate application of each.

Professional Employees or Contracted Individuals: (Indicate the total number of individuals in each category)

	Employed physicians
	Contracted physicians
	Employed surgeons
	Contracted surgeons
	Podiatrists
	Oral surgeons/Dentists
	Physician assistant/Surgeon assistant
	Nurse midwives
	Nurse anesthetists
	Nurse practitioner
	Psychologist
	Profusionists
	Chiropractor
	Certified Nurse Anesthetists
	Cytotechnologist
	Emergency Medical Technicians
	Residents/Interns
	Optometrist
	Total Number of Professionals

Other Covered Employees or Contractors: (Indicate the total number of individuals in each category.)

	Registered nurses
	LPN's
	Student nurses
	X-Ray technicians
	Pharmacists
	Physical Therapists
	Paramedics
	Volunteers
	Other employees
	Total Other Covered Individuals

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Section VI - Exposure Data Information

Facilities and Services Available: (Please check all that apply)

	Abortion Clinic		Ambulance		Blood Bank
	Burn Unit		CCU		Coronary Rescue
	Day Care		Dialysis		Dietary
	Emergency		Gift Shop		ICU
	Inhalation Therapy		Long-Term Care		Morgue
	Neonatal ICU		Nursery		Obstetrical
	Open Heart		Operating Rooms		Pathology
	Pharmacy		Physical Therapy		Radiation Therapy
	Radiology		Restaurant		Self-Care
	Shock Trauma		X-Ray		

Indicate if department is staffed by employees, contractors, or staff and limits of liability required? (Please provide verification of coverage for contract services)

Department	Staffing	Insurance Limits
Anesthesiology	❑ Employed Physicians ❑ Contract Physicians ❑ Staff Physicians	
Radiology	❑ Employed Physicians ❑ Contract Physicians ❑ Staff Physicians	
Emergency Department	❑ Employed Physicians ❑ Contract Physicians ❑ Staff Physicians	
Pharmacy	❑ Employed Pharmacists ❑ Contract Pharmacists ❑ Staff Pharmacists	

Professional Liability Exposures: (Please indicate zero where not applicable. Provide number of licensed beds and average occupied for past 12 months)

Acute Care:	# of Licensed Beds		Average # of Occupied Beds	
Subacute Care:	# of Licensed Beds		Average # of Occupied Beds	
Skilled Care:	# of Licensed Beds		Average # of Occupied Beds	
Assisted Living:	# of Licensed Beds		Average # of Occupied Beds	
Independent Living:	# of Licensed Beds		Average # of Occupied Beds	
Residential Care:	# of Licensed Beds		Average # of Occupied Beds	
Psychiatric/Mental Health Beds:	# of Licensed Beds		Average # of Occupied Beds	
Chemical Dependency / Rehabilitation Beds:	# of Licensed Beds		Average # of Occupied Beds	
ICU/CCU/NICU:	# of Licensed Beds		Average # of Occupied Beds	
Bassinets:	# of Licensed Beds		Average # of Occupied Beds	

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Inpatient Surgeries and Outpatient Visits: (Please indicate zero where not applicable. Provide number of procedures for previous 12 months and number of outpatient visits projected for the next 12 months)

Inpatient Surgeries:	# of Procedures		#of Outpatient Visits	
Outpatient Surgeries:	# of Procedures		#of Outpatient Visits	
Births Total: Vaginal Births Cesarean Sections	# of Procedures		#of Outpatient Visits	
Health Institutional (clinical) Visits:	# of Procedures		#of Outpatient Visits	
Chemical Dependency:	# of Procedures		#of Outpatient Visits	
Emergency Room Services:	# of Procedures		#of Outpatient Visits	
Counseling/Therapy Visits:	# of Procedures		#of Outpatient Visits	
Home Health/Hospice Visits:	# of Procedures		#of Outpatient Visits	
Mental Health (psychiatric) Visits:	# of Procedures		#of Outpatient Visits	
All other Outpatient Visits:	# of Procedures		#of Outpatient Visits	

How many surgical procedures were performed in the last year by:

Employed Physicians _____ Staff Surgeons _____ Interns _____ Residents _____

Do you operate an Emergency Room? ❑ Yes ❑ No

Level of care given in Emergency Room? ❑Level I ❑ Level II ❑ Level III ❑ Level IV

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Section VII - Rating Information

1. Does your institution engage in formal clinical research under the auspices of an institutional review board? ❑ Yes ❑ No
   If yes, please explain below.
2. Does your institution engage in administration of non-FDA approved pharmaceuticals? ❑ Yes ❑ No
   If yes, please explain below.
3. Does your institution engage in bio-medical device research and development? ❑ Yes ❑ No
   If yes, please explain below.
4. Does your institution engage in animal research? ❑ Yes ❑ No
   If yes, please explain below.
5. Does your institution engage in medical and/or surgical experimentation that is not approved by institutional review board? ❑ Yes ❑ No
   If yes, please explain below.
6. Have your licenses, certifications or ability to participate with Medicare or Medicaid ever been suspended, revoked, placed on probation or voluntarily surrendered? If yes, please explain below. ❑ Yes ❑ No
7. Do you own or operate a blood bank? ❑ Yes ❑ No

   If no, from where is the blood product obtained?
8. Does your facility meet current life safety code requirements as published in Fire/Code Uniform Fire Code? ❑ Yes ❑ No
   If no, please explain below.
9. Does your facility maintain a written patient transfer plan for all contingencies which includes providing appropriate continuity of care information to the receiving facility, notification of family or guardian of transfer, appropriate and safe transportation and an audit process that is monitored through committee? ❑ Yes ❑ No
10. Is your facility accredited by J.C.A.H.O. or A.H.C.A., or equivalent? ❑ Yes ❑ No

    If yes, does your accreditation have outstanding contingencies? ❑ Yes ❑ No

    NOTE: If your facility is a nursing home, a state license issued by the Missouri Department of Health and Senior Services, and a copy the state report meets this requirement.
11. Does your facility perform background checks on all staff who have patient or resident contact (employees, leased workers and volunteers) including criminal history (5 years), felonies, misdemeanors, sexual offenses, abuse, theft, assault, credit history, verification of all education, verification of references, US citizenship status/Visa, and substance test?

    If no, please explain below. ❑ Yes ❑ No
12. Does your facility operate solely in the State of Missouri? ❑ Yes ❑ No
13. Has the institution been required to notify the National Practitioner Data Bank of any suspension, peer review action or professional liability payment involving any member of the medical or dental staff?

    If yes, please explain below. ❑ Yes ❑ No
14. Do facility by-laws require staff doctors, employed doctors, and contract doctors to carry medical malpractice insurance of at least $1,000,000 each medical incident/$3,000,000 annual aggregate? ❑ Yes ❑ No

    NOTE: If the facility is a Nursing Home, and no physicians are employed or contracted, questions 14, 16, 17, 18, 19, and 20 do not apply.
15. Does your facility require certificates of insurance for all contract services? ❑ Yes ❑ No
16. Do you require all employed, contract, and staff doctors to be Board Certified or Board Eligible? ❑ Yes ❑ No
17. Are privileges probationary for at least six months for all staff doctors? ❑ Yes ❑ No
18. Are all new physicians required to be proctored by a member of the active medical staff? ❑ Yes ❑ No
19. Are staff physicians' privileges and overall performances evaluated periodically? ❑ Yes ❑ No
20. Are all privileges granted to staff physicians detailed in writing? ❑ Yes ❑ No
21. Does the facility utilize the unit-dose system of dispensing medicine? ❑ Yes ❑ No
22. Is the pharmacy for patient-use only? ❑ Yes ❑ No
23. Does any nursing service or nursing facility rely upon treatment by spiritual means alone in accordance with the creed or tenets of any well-recognized church or religious denomination? ❑ Yes ❑ No

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Provide detailed explanations below:

Section VIII - Risk Management

Who coordinates your risk management program? Name: _____ Title: _____ Telephone Number: _____	
Is there a written risk management program that has been approved by a governing body?	❑ Yes ❑ No
Is the risk manager accountable and solely responsible for risk management?	❑ Yes ❑ No
Does your facility maintain a written continuing education plan which includes risk management topics for nursing, physicians, administration, governing board and department heads?	❑ Yes ❑ No
Does your risk management program include occurrence reporting?	❑ Yes ❑ No
Does your risk management program include review and participation in medical staff committees?	❑ Yes ❑ No
Does your risk management program include contract review and evaluation?	❑ Yes ❑ No
Does your risk management program include claim management?	❑ Yes ❑ No
Does your risk management program include safety program and safety committee?	❑ Yes ❑ No

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Section IX - Loss Information

1. Are you now, or have you ever been involved, directly or indirectly in a claim, potential claim, or a suit arising out of the rendering or failing to render professional services? ❑ Yes ❑ No

   If "Yes" A. Indicate number closed, dropped, dismissed _____

   B. Indicate number pending or open _____

   C. Total number of cases (A+B) _____

   If "Yes," Have all claim/suits indicted in"C" above been reported to your current or prior professional liability carrier? ❑ Yes ❑ No

2. Other than those claims/suits indicated in question 1 above, do you have knowledge of any incident, potential claim, suit, or circumstances that might reasonably lead to a claim or suit being brought against you arising out of the rendering or failing to render professional services ? ❑ Yes ❑ No

   If "Yes" How many? _____

   If "Yes" Have all circumstances that might reasonably lead to a claim or suit (even if you believe the possible claim or suit would be without merit) been reported to your current or prior professional liability carrier? ❑ Yes ❑ No

Important: **For each loss indicated in questions 1 and 2 above 1) you are required to complete the attached Supplementary Loss Information Form and 2) A 5-Year Carrier Loss Run is needed from your current and/or previous professional liability carrier(s). The Loss Run should include date of occurrence, date of report, description,, indemnity amount paid, indemnity amount reserved, defense amount paid, defense amount reserved and current status.**

Section X - Nursing Care Facilities Only

1. Years under current management: _____
2. Does a management company manage the facility? ❑ Yes ❑ No
   If yes, Name of Management Company: _____
   If yes, Number of years with current company: _____
3. Total number of units: _____
4. Total number of residents at full occupancy: _____
5. There is documentation that Residents are attended to on a daily basis? ❑ Yes ❑ No
6. Are residents allowed to have home health care aids? ❑ Yes ❑ No
7. Is the Director of Nursing a Registered Nurse? ❑ Yes ❑ No
8. Do you require nurses to carry malpractice coverage? ❑ Yes ❑ No
9. Total number of nurse employees? _____
10. Is a nursing assessment conducted and documented for every new resident immediately upon admission? ❑ Yes ❑ No

    If "Yes" does this assessment include evaluation of:

- Full body skin breakdown/decubiti ❑ Yes ❑ No
- Mobility limitations ❑ Yes ❑ No
- Urinary incontinence ❑ Yes ❑ No
- History of prior injuries ❑ Yes ❑ No
- Required assistance ❑ Yes ❑ No
- Orientation/cognition ❑ Yes ❑ No
- Current medications ❑ Yes ❑ No
- Fall risk ❑ Yes ❑ No

- Wandering tendencies ❑ Yes ❑ No
- Nutritional needs ❑ Yes ❑ No
- Risk of provoking or initiating abusive behavior? ❑ Yes ❑ No

11. How often are your residents reassessed? _____

12. Does the facility have a policy clearly identifying the types of dementia residents for whom staff is capable of providing care: ❑ Yes ❑ No

    If "Yes", please attach policy.

13. Does your facility have a secured unit(s) for residents prone to wandering? ❑ Yes ❑ No

    If "Yes":
    - Are all exit doors alarmed and/or physically monitored? ❑ Yes ❑ No
    - Are alarm bracelets used in the facility? ❑ Yes ❑ No
    - Is a care plan developed and implemented for each identified wandering resident? ❑ Yes ❑ No

14. Does staff receive training and education regarding wandering residents and associated management strategies? ❑ Yes ❑ No

15. Are fall assessments performed:
    - Following any acute change of condition? ❑ Yes ❑ No
    - When there is a change in medication regimen? ❑ Yes ❑ No
    - When there is a change in treatment plan? ❑ Yes ❑ No
    - At least quarterly? ❑ Yes ❑ No

16. Does the facility have and enforce a policy regarding smoking in and around the facility? ❑ Yes ❑ No

17. Are residents and visitors who are smoking properly monitored? ❑ Yes ❑ No

18. Are regular rounds performed and documented of the physical plant and grounds, to ensure they are in a safe and well maintained condition? ❑ Yes ❑ No

19. Are equipment checks and preventive maintenance routinely performed and documented? ❑ Yes ❑ No

20. Is staff education on wound prevention and treatment provided and documented? ❑ Yes ❑ No

21. Are policies and procedures on assisting residents with self-medication and administering medication in place? ❑ Yes ❑ No
    If "Yes" please provide a copy.

22. Are protocols in place for notification of resident's health care provider in cases of Acute Change of Condition? ❑ Yes ❑ No
    If "Yes" please provide a copy.

23. Is there a written Emergency Evacuation Plan for the facility? ❑ Yes ❑ No
    If "Yes" please provide a copy

24. Does staff orientation include a review and drill of any disaster plan? ❑ Yes ❑ No

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Section XI - General Liability

Location and Occupancy Including Patient Care Buildings, Other Buildings and Parking Lots	Square Footage	Age	Type of Construction	Number of Floors	Type of Fire Protection

1.	Does your facility include a swimming pool?	❑ Yes	❑ No
2.	Hot tub/sauna?	❑ Yes	❑ No
3.	Exercise/weight room?	❑ Yes	❑ No
4.	Gymnasium?	❑ Yes	❑ No
	Please provide details below. A separate charge will be made for each of these facilities.		
	If yes to questions 1-4, do you allow use of these facilities by sports teams, clubs or other outside entities?	❑ Yes	❑ No
	If yes, do you make a charge for this usage?	❑ Yes	❑ No
	Do you require signed hold harmless agreements from each person/organization entering your premises for these activities?	❑ Yes	❑ No
5.	Do you have a heliport? (if yes, please provide verification of coverage)	❑ Yes	❑ No
6.	Are there elevators or escalators on any premises?	❑ Yes	❑ No
7.	Do you have planned any new construction and/or abatement for this year?	❑ Yes	❑ No
8	Has your facility agreed to hold harmless or indemnify others under contract?	❑ Yes	❑ No
9	Does your facility rent or lease any equipment from others?	❑ Yes	❑ No
10.	Are there dwellings or other buildings rented or leased to others located on your premises? (Please provide details below. A separate charge will be made)	❑ Yes	❑ No
11.	Does your facility include a cafeteria where meals are served to visitors or the general public for a charge?	❑ Yes	❑ No
	If yes, please provide annual receipts	_____	
12.	Does your facility include rooms that are offered to non-affiliated entities for meetings or events?	❑ Yes	❑ No
	If yes, please provide square footage of these rooms	_____	

If any answer to questions1-12 above is "Yes", please provide details and explanation below:

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Please Read and Sign

.

I hereby declare that the above statements and particulars are true and that I have not knowingly suppressed or misstated any material facts and I agree that this application shall be the basis of the contract with the company. I agreed to notify the company if there is any future material change in any answers to this application, including without limitation, any change in my professional specialty, affiliation or working arrangement with any other physician, firm or professional association.

I UNDERSTAND THAT ANY MATERIAL MISPRESENTATION OR OMISSION MADE BY ME ON THIS APPLICATION MAY ACT TO RENDER ANY CONTRACT OF INSURANCE NULL AND WITHOUT AFFECT, PROVIDE THE COMPANY WITH THE RIGHT TO RESCIND IT, AND/OR REQUIRE RETROACTIVE UPWARD PREMIUM ADJUSTMENT.

_____ _____

Applicant's Signature **Date**

_____ _____

Applicant's Name **Applicant's Title**

.

Application Checklist:

- ❑ Copy of most current declaration page
- ❑ Five-year Company Loss History
- ❑ Copy of Business Letterhead
- ❑ Supplemental Loss Information for each loss
- ❑ Allied Health Care Provider Application for each Allied Health Care Provider
- ❑ Signature and Date on Application
- ❑ Verification of Extended Reporting or Prior Acts Coverage
- ❑ Most recent accrediting agency (JCAHO, AOA, CARF, etc.) and state licensure report with recommendations and the institution's response to any contingencies
- ❑ Copy of medical staff by-laws
- ❑ A.H.A. Survey of hospitals
- ❑ Risk Management and quality improvement plan
- ❑ Verification of professional liability coverage for all contracted services
- ❑ All hold harmless agreements
- ❑ Completed, Signed Authorization to Release Information
- ❑ Copy of Missouri License

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Supplementary Loss Information

Please complete the Supplementary Loss Information for each case indicated in Section VIIII - Loss Information questions 1 and 2. Please photocopy this form. All questions must be answered or marked Not applicable (N/A).

Patient's name: _____ Date of incident and your treatment: _____

Name of Insurance Company: _____ Date Reported to Insurance Company: _____

Allegations: _____

_____

Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ❑ Yes ❑ No

What is the status of this matter? ❑ Open ❑ Closed (Check applicable description below)

❑ Incident report only ❑ Suit threatened, no action taken ❑ Suit filed but dropped by claimant

❑ Summary judgment in your favor ❑ Jury verdict in your favor ❑ Jury verdict in favor of the plaintiff

❑ Suit settled out of court ❑ Suit filed awaiting mediation ❑ Suit filed awaiting court action

If closed, amount of loss payment: _____ Date paid: _____

-

If open, amount of loss reserve: _____

Supplementary Loss Information

Please complete the Supplementary Loss Information for each case indicated in Section VIIII - Loss Information questions 1 and 2. Please photocopy this form. All questions must be answered or marked Not applicable (N/A).

Patient's name: _____ Date of incident and your treatment: _____

Name of Insurance Company: _____ Date Reported to Insurance Company: _____

Allegations: _____

_____

Did you in any way alter, embellish, delete, change, and/or destroy any records, medical or otherwise, or were allegations made that you did so, pertaining to this claim? ❑ Yes ❑ No

What is the status of this matter? ❑ Open ❑ Closed (Check applicable description below)

❑ Incident report only ❑ Suit threatened, no action taken ❑ Suit filed but dropped by claimant

❑ Summary judgment in your favor ❑ Jury verdict in your favor ❑ Jury verdict in favor of the plaintiff

❑ Suit settled out of court ❑ Suit filed awaiting mediation ❑ Suit filed awaiting court action

If closed, amount of loss payment: _____ Date paid: _____

If open, amount of loss reserve: _____

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AUTHORIZATION TO RELEASE INFORMATION

The undersigned applicant for insurance by Missouri Medical Malpractice Joint Underwriting Association (the "Association"") hereby authorizes his present and prior professional liability insurance carriers and any and all attorneys who have represented the undersigned in connection with any claim of professional liability to release to the Association upon its request information regarding closed, pending, or anticipated claims and any underwriting or other information which in the judgment of any such carrier, attorney, or the Association may have a bearing upon his acceptability to the Association as a professional liability insurance risk.

The undersigned also authorizes all medical associations and medical societies in which he is or has been a member, all hospitals in which he now holds or has held staff privileges, the State Board of Medical Examiners for the State of Missouri and any other State in which he has practiced, or resided, and any and all physicians having information regarding the undersigned, to release to the Association upon its request any information any such person or entity may have which in the judgment of any such person or entity or the Association may have a bearing upon his acceptability to the Association as a professional liability insurance risk.

The undersigned hereby releases and agrees to hold harmless all persons or organizations releasing the information described above, their agents, servants, and employees, and the Association, its directors, officers, employees, agents, and members from any liability arising out of the release or use of any information released or furnished pursuant to this authorization, notwithstanding the fact that there may be errors, omissions, or mistakes contained in such released information.

The undersigned hereby acknowledges that persons and organizations releasing information described above will be advised that their identity, and the information they provide, will be held in confidence and will not be disclosed to the undersigned. The undersigned agrees that the undersigned shall not seek to discover or compel the disclosure, through judicial process, litigation or otherwise, of the identity of the persons or organizations releasing information described above or of the form or content of the information so provided, and the undersigned hereby expressly waives any right the undersigned may have to compel such disclosure.

The undersigned further agrees that the Association and all persons and organizations described above may rely upon a photocopy of this Authorization, which shall be of equal validity with the signed original.

Name (Printed): _____

Signature: _____

Address: _____

_____

Date: _____