Supplement for Home Healthcare, Nurse Registry, Infusion Therapy, or Other Medical Staffing for Professional Liability Insurance for Specified Medical Professions

Please supply this supplement with completed application if required.

Rockwood Programs, Inc., 4001 Miller Road, Wilmington, DE 19802-1999
Toll-Free: (800) 558-8808 • Fax: (302) 765-6039 • Email: www.rockwoodinsurance.com

All questions MUST be completed in full. If space is insufficient to answer any question fully, attach a separate sheet.

1. Full name of Applicant: ______________________________

2. Type of Firm (check all that apply) ☐ Home Healthcare ☐ Infusion Therapy ☐ Visiting Nurse Agency
   ☐ Nurse Registry ☐ Other Medical Staffing (specify): ______________________________

3. Date Established: ____________________

4. Locations(s) where services are provided (Total must equal 100%)
   Home _______% Hospice _______% Nursing Home _______% Assisted Living Facility _______% Hospital _______%
   Clinic/Doctor's Office _______% Adult Day Care _______% Other Facility (specify):____________________ _______%

5. Employees/Independent Contractors—Annual Staffing

Type of Employee/Independent Contractor	Number Full-Time	Number Part-Time	Billable Hours Per Year
Employed Registered Nurse			
Contracted Registered Nurse			
Employed Licensed Practical Nurse			
Contracted Licensed Practical Nurse			
Employed Certified Nurse Assistant			
Contracted Certified Nurse Assistant			
Employed Nurse Practitioner/Physician Assistant			
Contracted Nurse Practitioner/Physician Assistant			
Employed Companion/Home Health Aide			
Contracted Companion/Home Health Aide			
Employed Social Worker			
Contracted Social Worker			
Employed Physical Therapist			
Contracted Physical Therapist			
Employed Other Medical, specify: ____________			
Contracted Other Medical, specify: ____________			

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by the Applicant, officer, partner or equivalent (within 60 days of the proposed effective date).

Name of Applicant ______________________________ Title ______________________________

Signature of Applicant ______________________________ Date ____________________