



**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](http://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

<b>Type of Employee/Independent Contractor</b>	<b>Number Full-Time</b>	<b>Number Part-Time</b>	<b>Billable Hours Per Year</b>
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 \_\_\_\_\_