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CHIROPODIST/PODIATRIST SUPPLEMENT
Forming part of the Professional Liability Application

Name of Applicant

Provide name and location of university where DPM degree obtained:

Are you a member of your provincial College of Chiropodists 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 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 Reprsentative

DATE: D D M M Y Y

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