



National Governing Alliance
of Allied Health Professionals

MEDICAL ASSISTANT PROGRAM MEMBERSHIP APPLICATION



CONTACT AND PRACTICE INFORMATION:

Full Name (First, Middle, Last)		Practice / Clinic Name	
Office Address (include Suite #)	City	State	Zip
Mailing Address – If Different from Office Address	City	State	Zip
Office Phone	Alternate Phone (Home, Cell, etc.)	Fax	Email
Social Security Number	Birth Date	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
<input type="checkbox"/> Practitioner	Personal Trainer School Attended (Students provide School attending & expected completion info)		Graduated
<input type="checkbox"/> Student			Hours Completed

PROFESSIONAL INFORMATION (STUDENTS SKIP TO QUESTION 9)

1. What current Medical Assistant Certification do you hold? AAMA NGAHP NHA Other _____ None
2. Has any malpractice claim or proceeding ever been brought against you, your associates or employees; or In the last three years has anyone asserted that your care, treatment or diagnosis was deficient or caused them harm? (If YES, provide details) Yes No
3. Has any agency or association investigated or taken any other action against you or your certification? (If YES, explain) Yes No
4. Have you ever had liability insurance refused, declined, canceled, or accepted on special terms? (If YES, explain) Yes No
5. Have you ever used any drug or substance that interfered with your ability to perform Medical Assist. duties? (If YES, explain) Yes No
6. Have you ever been convicted of any violation of the law other than a minor traffic offense? (If YES, explain) Yes No
7. Do you: do colonic irrigations, treat cancer, epilepsy, practice obstetrics or make a differential diagnosis? (If YES, explain) Yes No
8. Are you always supervised by a Medical Doctor when performing Medical Assistant duties? (If NO, explain) Yes No

Medical Doctor's Name: _____

M.D.'s Malpractice Carrier: _____ Policy Expires: _____

9. Do you *always* follow procedures as delegated to you by your Supervising Physician? (If NO, explain) Yes No
10. Do you perform any Medical Assistant duties other than those taught at your Medical Assistant school? (If YES, explain) Yes No
11. Do you *always* comply with quality assurance practices? Yes No
12. Do you *always* screen and follow up on patient test results? Yes No
13. Do you *always* apply principles of aseptic technique and infection control? Yes No
14. Clinical Duties - Check each of the following Clinical Duties you have performed or expect to perform for your Supervising Physician(s).

<input type="checkbox"/> Obtain Patient History	<input type="checkbox"/> Prepare and maintain examination and treatment areas
<input type="checkbox"/> Take Vital Signs	<input type="checkbox"/> Assist with examinations, procedures and treatments
<input type="checkbox"/> Collect and process specimens	<input type="checkbox"/> Prepare and administer medications and immunizations
<input type="checkbox"/> Perform Diagnostic Tests	<input type="checkbox"/> Initiate and administer IV medications (if permitted by law)
<input type="checkbox"/> Prepare patients for examinations, procedures and treatments	<input type="checkbox"/> Coordinate patient care with other Health Care Providers

PROFESSIONAL INFORMATION (Continued from Page 1)

15. List any other Clinical Duties you perform: _____

16. List other health professions you are licensed to practice (RN, LMT, LAC, etc.) _____
17. Who provides your malpractice insurance for that profession? _____ Policy Expires: _____
18. Do you currently have Medical Assist coverage? Yes No If YES, Carrier: _____ Policy Expires _____
19. List any entity you want as an additional insured (cost is \$25 /entity): _____
20. Your Medical Assistant insurance, if approved, will be effective the date your app is received. For a later date, specify here: _____

MEMBERSHIP OPTIONS AND PAYMENT

Professional & Student Membership includes \$1 million / \$3 million Professional & Premises Liability Coverage. Fellowship & Affiliate categories do not include coverage. Check the following box if you do not want \$10 of your Membership to go to the NGAHP Pac.

- | | | |
|---|-----------|-------|
| <input type="checkbox"/> Professional | @ \$299 = | _____ |
| <input type="checkbox"/> Student | @ \$199 = | _____ |
| <input type="checkbox"/> Fellowship | @ \$100 = | _____ |
| <input type="checkbox"/> Additonal Profession | @ \$50 = | _____ |
| <input type="checkbox"/> Additional Insured | @ \$25 = | _____ |
- TOTAL AMOUNT DUE:** _____

- Check MasterCard Visa Discover AMEX
- Card #: _____ Expires: _____

SIGN THEN FAX OR MAIL APPLICATION

I hereby apply for membership and / or coverage. If provided, charge my credit card for the amount indicated. I declare that the above statements are true and I have not suppressed or misstated any facts. I agree that this declaration shall be a basis for, and form a part of, my professional liability policy and my NGAHP membership. I understand untrue statements could void my policy and / or my NGAHP membership. I understand that, I have a duty to report in writing, within 48 hours, or as soon as practicable, any incidents reasonably likely to involve this insurance, including oral or written patient complaints, or threats or filings of lawsuits. I understand that Returned checks will be charged a \$35.00 administrative fee.

SIGN: _____ DATE: _____

REMIT TO: **AHS** (American Health Source)
 801 W. NORTON AVE, SUITE 420 MUSKEGON MI 49441
 888-375-7245 - PHONE 231-733-0746 - FAX