

**SUPPLEMENTARY APPLICATION  
 ERRORS & OMISSIONS LIABILITY INSURANCE  
 ELECTROLYSIS/ELECTROLOGISTS**



1. Name of Applicant	
2. What method do you use for electrolysis treatment?	
	Yes                  No
Electrolysis	<input type="checkbox"/> <input type="checkbox"/>
Thermolysis	<input type="checkbox"/> <input type="checkbox"/>
Blend	<input type="checkbox"/> <input type="checkbox"/>
3. Do you use disposable needles? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, describe method used for sterilization of needles:	
_____	
_____	
Is the sterilization machine C.S.A. approved? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Do you perform any treatment on warts, moles, growths or other type of surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, provide details:	
_____	
_____	
Do you obtain written authorization for this treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, what are the qualifications:	
_____	
_____	
Where are procedures performed? <input type="checkbox"/> Hospital <input type="checkbox"/> Office	
5. Do you have clients complete a health questionnaire prior to providing treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>DECLARATION</b>	
The undersigned declares that all statements made in the Supplementary Application are true. Signing of this document does not bind the Applicant to complete the insurance, but it is agreed that the Application and Supplementary Application shall be the basis of the contract, should a policy be issued.	
_____ Signature	_____ Title or Position
_____ Date	<b>Must be signed by a Principal, Partner, Controller, Executive Officer or Director.</b>