

Texas Medical Liability Insurance Underwriting Association (JUA)

505 East Huntland Drive, Suite 160 • Austin, Texas 78752
(512) 452-4370

APPLICATION FOR MEDICAL (PROFESSIONAL) LIABILITY INSURANCE PHYSICIANS AND OTHER NON-INSTITUTIONAL HEALTH CARE PROVIDERS

To the above designated Association:

As a licensed physician or other non-institutional health care provider entitled in good faith to medical liability insurance in Texas, the undersigned hereby makes application for such insurance in accordance with the provisions of Chapter 2203 of the Insurance Code of Texas, as amended, and the Plan of Operation of the Texas Medical Liability Insurance Underwriting Association ("ASSOCIATION") created in such Article. **THE UNDERSIGNED RECOGNIZES AND AGREES THAT IF HE OR SHE IS ISSUED A POLICY OF MEDICAL (PROFESSIONAL) LIABILITY INSURANCE PURSUANT TO THIS APPLICATION, HE OR SHE MAY BE ASSESSED IN AN AMOUNT NOT TO EXCEED ONE HUNDRED PERCENT (100%) OF THE PREMIUM PAID FOR THIS POLICY, AND THAT IF HE OR SHE SHOULD FAIL TO PAY SUCH ASSESSMENT WHEN LEVIED AGAINST HIM OR HER, THAT THIS POLICY AND ANY OTHER POLICY INSURING THE UNDERSIGNED WHICH IS WRITTEN THROUGH THE ASSOCIATION MAY BE CANCELLED, AND THE UNEARNED PREMIUM OTHERWISE REFUNDABLE ON SUCH POLICY (OR POLICIES) MAY BE OFFSET BY THE ASSOCIATION AGAINST THE AMOUNT OF SUCH UNPAID ASSESSMENT.** The undersigned further recognizes and agrees that such insurance as is applied for herewith is subject to such rates, premium modifications, surcharges and policyholder's stabilization reserve fund charges as are now or may hereafter be approved by the Texas Department of Insurance. The undersigned further agrees that the Producer of Record herein shown acts solely as the agent of the undersigned and is not an agent of or for the ASSOCIATION or of the company assigned to issue and service such insurance.

1. The insurance herewith applied for has been tendered to and rejected by two carriers, including insurers licensed and engaged in writing the coverage applied for in Texas or self-insurance trust created under Insurance Code Chapter 2212. These rejections are a condition precedent to applying to the ASSOCIATION for insurance.

Name of Rejecting Carriers: (1) _____ (2) _____

Date of Rejections: (1) _____ (2) _____

2. a. **APPLICANT'S FULL NAME:** _____ Date of Birth _____

b. Mailing Address: _____
Street City County State Zip

c. Practice Address: _____
Street City County State Zip

d. Email address for insured: _____

e. Email address for office manager: _____

- f. Provide name of **EACH** facility at which you have staff membership or privileges and **ATTACH** a copy of your clinical privileges approved at **EACH**. Attach addendum if additional space is needed. **THIS IS A MANDATORY REQUIREMENT. COVERAGE CANNOT BE BOUND WITHOUT THIS INFORMATION.**

_____	_____
_____	_____
_____	_____
_____	_____

3. Check the TYPE OF COVERAGE desired:

Occurrence

Claims-Made: Check one of the following:

First Year

Prior Acts Coverage (You must complete form JUA-82 and attach copy of your current/most recent declaration's page)

Retro Date Desired: _____

4. Future EFFECTIVE DATE Desired: _____

5. **My Medical Professional Specialty is:** _____

IMPORTANT: You MUST check "✓" all areas which are included in your medical practice or profession even if performed infrequently.

SPECIALTY OR PROCEDURE	CLASS CODE	SPECIALTY OR PROCEDURE	CLASS CODE
<input type="checkbox"/> Acupuncture	80437	<input type="checkbox"/> Hematology/Oncology	
<input type="checkbox"/> Aerospace Medicine	80230	<input type="checkbox"/> No surgery	80245
<input type="checkbox"/> Allergy	80254	<input type="checkbox"/> Minor surgery	80278
<input type="checkbox"/> Anesthesiology	80151	<input type="checkbox"/> Hypnosis	80232
<input type="checkbox"/> Angiography	80422	<input type="checkbox"/> Infectious Diseases	
<input type="checkbox"/> Arteriography	80422	<input type="checkbox"/> No surgery	80246
<input type="checkbox"/> Bronchoesophagology	80101	<input type="checkbox"/> Minor surgery	80279
<input type="checkbox"/> Cardiovascular Disease		<input type="checkbox"/> Intensive Care Medicine	80283
<input type="checkbox"/> No surgery	80255	<input type="checkbox"/> Internal Medicine	
<input type="checkbox"/> Minor surgery	80281	<input type="checkbox"/> No surgery	80257
<input type="checkbox"/> Catheterization	80422	<input type="checkbox"/> Minor surgery	80284
<input type="checkbox"/> Colonoscopy	80443	<input type="checkbox"/> Laparoscopy	80440
<input type="checkbox"/> Dentistry-excluding oral surgery		<input type="checkbox"/> Laryngology	
<input type="checkbox"/> *or operative dentistry	80211	<input type="checkbox"/> No surgery	80258
<input type="checkbox"/> Dentistry-including oral surgery		<input type="checkbox"/> Minor surgery	80285
<input type="checkbox"/> *or operative dentistry	80210	<input type="checkbox"/> Lasers	80425
<input type="checkbox"/> Dermatology		<input type="checkbox"/> Legal Medicine	80240
<input type="checkbox"/> No surgery	80256	<input type="checkbox"/> Lymphangiography	80434
<input type="checkbox"/> Minor surgery	80282	<input type="checkbox"/> Myelography	80428
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Needle Biopsy-lung or prostate	80446
<input type="checkbox"/> No surgery	80237	<input type="checkbox"/> Neoplastic Diseases	
<input type="checkbox"/> Minor surgery	80271	<input type="checkbox"/> No surgery	80259
<input type="checkbox"/> Discograms	80428	<input type="checkbox"/> Minor surgery	80286
<input type="checkbox"/> Emergency Medicine		<input type="checkbox"/> Nephrology	
<input type="checkbox"/> No major surgery	80102	<input type="checkbox"/> No surgery	80260
<input type="checkbox"/> Including major surgery	80157	<input type="checkbox"/> Minor surgery	80287
<input type="checkbox"/> Endocrinology		<input type="checkbox"/> Neurology	
<input type="checkbox"/> No surgery	80238	<input type="checkbox"/> No surgery	80261
<input type="checkbox"/> Minor surgery	80272	<input type="checkbox"/> Minor surgery	80288
<input type="checkbox"/> ERCP	80443	<input type="checkbox"/> Nuclear Medicine	80262
<input type="checkbox"/> Family or General Practice		<input type="checkbox"/> Nurse (Registered) Practitioner	80998P
<input type="checkbox"/> No surgery	80420	<input type="checkbox"/> Nurse (Registered)	80998
<input type="checkbox"/> Minor surgery	80421	<input type="checkbox"/> Nurse (CRNA)	80960
<input type="checkbox"/> Forensic Medicine	80240	<input type="checkbox"/> Nurse (Certified)-Midwife	
<input type="checkbox"/> Gastroenterology		<input type="checkbox"/> Births	80962
<input type="checkbox"/> No surgery	80241	<input type="checkbox"/> Nurse (Certified)-Midwife	
<input type="checkbox"/> Minor surgery	80274	<input type="checkbox"/> No Births	80963
<input type="checkbox"/> General Preventive Medicine	80231	<input type="checkbox"/> Nurse (Registered)-	
<input type="checkbox"/> Geriatrics		<input type="checkbox"/> X-Ray Therapists	80714
<input type="checkbox"/> No surgery	80243	<input type="checkbox"/> Nutrition	80248
<input type="checkbox"/> Minor surgery	80276	<input type="checkbox"/> Occupational Medicine	80233
<input type="checkbox"/> Gynecology		<input type="checkbox"/> Ophthalmology	
<input type="checkbox"/> No surgery	80244	<input type="checkbox"/> No surgery	80263
<input type="checkbox"/> Minor surgery	80277	<input type="checkbox"/> Minor surgery	80289

5. Specialty or Procedure (continued)

SPECIALTY OR PROCEDURE	CLASS CODE	SPECIALTY OR PROCEDURE	CLASS CODE
<input type="checkbox"/> Otolaryngology		<input type="checkbox"/> Surgery-abdominal	80166
<input type="checkbox"/> No surgery	80264	<input type="checkbox"/> Surgery-bariatric	80166B
<input type="checkbox"/> Minor surgery	80290	<input type="checkbox"/> Surgery-cardiac	80141
<input type="checkbox"/> Otorhinolaryngology		<input type="checkbox"/> Surgery-cardiovascular	80150
<input type="checkbox"/> No surgery	80265	<input type="checkbox"/> Surgery-colon and rectal	80115
<input type="checkbox"/> Minor surgery	80291	<input type="checkbox"/> Surgery-endocrinology	80103
<input type="checkbox"/> Pathology		<input type="checkbox"/> Surgery-gastroenterology	80104
<input type="checkbox"/> No surgery	80266	<input type="checkbox"/> Surgery-Family or General Practice not primarily engaged in major surgery	80117
<input type="checkbox"/> Minor surgery	80292	<input type="checkbox"/> Surgery-general	80143
<input type="checkbox"/> Pediatrics		<input type="checkbox"/> Surgery-geriatrics	80105
<input type="checkbox"/> No surgery	80267	<input type="checkbox"/> Surgery-gynecology	80167
<input type="checkbox"/> Minor surgery	80293	<input type="checkbox"/> Surgery-hand	80169
<input type="checkbox"/> Perfusionist	P80151	<input type="checkbox"/> Surgery-head and neck	80170
<input type="checkbox"/> Phlebography	80434	<input type="checkbox"/> Surgery-laryngology	80106
<input type="checkbox"/> Physiatry	80235	<input type="checkbox"/> Surgery-maxillofacial	80155
<input type="checkbox"/> Physical Medicine & Rehabilitation	80235	<input type="checkbox"/> Surgery-neoplastic	80107
<input type="checkbox"/> Pneumoencephalography	80428	<input type="checkbox"/> Surgery-nephrology	80108
<input type="checkbox"/> Podiatry (No Surgery)	80993	<input type="checkbox"/> Surgery-neurology	80152
<input type="checkbox"/> Podiatry (Surgery)	80993S	<input type="checkbox"/> Surgery-obstetrics	80168
<input type="checkbox"/> Psychiatry	80249	<input type="checkbox"/> Surgery-obstetrics-gynecology	80153
<input type="checkbox"/> Psychoanalysis	80250	<input type="checkbox"/> Surgery-ophthalmology	80114
<input type="checkbox"/> Psychosomatic Medicine	80251	<input type="checkbox"/> Surgery-orthopedic	80154
<input type="checkbox"/> Public Health	80236	<input type="checkbox"/> Surgery-otology	80158
<input type="checkbox"/> Pulmonary Disease	80269	<input type="checkbox"/> Surgery-otorhinolaryngology	80159
<input type="checkbox"/> Radiation Therapy	80425	<input type="checkbox"/> Surgery-plastic	80156
<input type="checkbox"/> Radiology		<input type="checkbox"/> Surgery-plastic-otorhinolaryngology	80155
<input type="checkbox"/> No surgery	80253	<input type="checkbox"/> Surgery-rhinology	80160
<input type="checkbox"/> Minor surgery	80280	<input type="checkbox"/> Surgery-thoracic	80144
<input type="checkbox"/> Radiopaque Dye Injections	80449	<input type="checkbox"/> Surgery-traumatic	80171
<input type="checkbox"/> Rheumatology	80252	<input type="checkbox"/> Surgery-urological	80145
<input type="checkbox"/> Rhinology		<input type="checkbox"/> Surgery-vascular	80146
<input type="checkbox"/> No surgery	80247	<input type="checkbox"/> Therapeutic abortion	80437
<input type="checkbox"/> Minor surgery	80270	<input type="checkbox"/> Weight control-as a specialty	80437
<input type="checkbox"/> Shock Therapy	80431		

*Dentistry procedures that require any cutting that may require suturing shall be considered oral surgery or operative dentistry.

6. Do you perform any procedures not customary to your specialty? (If yes, please list) Yes No

7.. a. Check the LIMITS OF LIABILITY desired:

- | | |
|---|--|
| <input type="checkbox"/> \$100,000./\$ 300,000. | <input type="checkbox"/> \$ 300,000./\$ 900,000. |
| <input type="checkbox"/> \$200,000./\$ 600,000. | <input type="checkbox"/> \$ 500,000./\$1,500,000. |
| <input type="checkbox"/> \$250,000./\$ 750,000. | <input type="checkbox"/> \$1,000,000./\$3,000,000. |

b. If a deductible is desired, check one of the PER CLAIM DEDUCTIBLES shown below. A DEDUCTIBLE IS NOT MANDATORY.

- \$ 0 \$ 2,500 \$ 5,000 \$ 10,000 \$ 15,000 \$ 20,000 \$ 25,000

8.. Do you perform any one or more of the following procedures?

- a. Minor** surgery other than incision of boils and superficial abscesses, or suturing of skin and superficial fascia Yes No
- b. Assisting in major** surgical procedures on your own patients Yes No
- c. Assisting in major surgical procedures on other than your own patients Yes No
- d. Major surgery (includes procedures done under general, spinal or caudal anesthesia)..... Yes No
- e. Normal deliveries of newborns Yes No
- f. Percutaneous biopsy for diagnostic study of organs or structures other than skin or superficial fascia Yes No
- g. Weight control surgery or procedures. Describe procedures..... Yes No
- h. Prenatal care Yes No

**Tonsillectomies, Adenoidectomies and Cesarean Sections are considered to be major surgical procedures.

i. Administer Anesthesia

1. General

-To your own patients? Yes No

-Is general anesthesia administered in your office? Yes No

If yes, list who administers and explain relationship:

-Is general anesthesia administered in a hospital or surgicenters? Yes No

If yes, list who administers and explain relationship:

2. Spinal Yes No

3. Caudal Yes No

4. Acupuncture Yes No

j. Treat by intravenous or intramuscular sedation Yes No

-Is treatment administered in your office? Yes No

If yes, list who administers and explain relationship:

-Is treatment administered in a hospital or surgicenters? Yes No

If yes, list who administers and explain relationship:

k. Catheterization-arterial, cardiac or diagnostic-other than (1) the occasional emergency insertion of pulmonary wedge pressure recording catheters or temporary pacemakers, (2) urethral catheterization or (3) umbilical cord catheterization for diagnostic purposes or for monitory blood gases in newborns receiving oxygen Yes No

l. Needle biopsy (Please explain, i.e. lung, liver, kidney, breast, etc.) _____ Yes No

m. Pneumatic or mechanical esophageal dilatation (not with bougie or olive) Yes No

n. Radiopaque Dye-injections into blood vessels, lymphatics, sinus tracts or fistulae Yes No

o. Lumbar epidural steroid injections Yes No

p. Cervical epidural steroid injections Yes No

q. Selective nerve root blocks Yes No

r. Sacroiliac joint injections Yes No

s. Lumbar facet injections Yes No

t. Cervical facet injections Yes No

u. Selective occipital nerve blocks Yes No

v. Trigger point injections Yes No

w. Joint Injections Yes No

x. Sympathetic nerve blocks Yes No

- y. Spinal taps/Lumbar punctures..... Yes No
- z. Closed reductions Yes No
- aa. Paracentesis Yes No
- bb. Thoracentesis Yes No
- cc. Circumcisions Yes No
- dd. Chemotherapy..... Yes No

If yes, explain how it is administered:

ee. BOTOX Injections for:

- 1. Muscle relaxant..... Yes No
- 2. Anti-wrinkle or other cosmetic purposes..... Yes No
- 3. Migraines..... Yes No
- 4. Abnormal sweating..... Yes No
- 5. Other (describe in detail)..... Yes No

6. Describe training and qualifications of all persons administering BOTOX in connection with your practice:

7. If administered in any setting other than in your medical office at which other professional services are rendered, explain in detail:

8. Attach a copy of the informed consent agreement patients are required to review and sign prior to treatment with BOTOX.

- ff. Wound Care (Please furnish list of procedures)..... Yes No
- gg. Neonatology..... Yes No
- hh. Telemedicine (Please explain)..... Yes No
- ii. Do you perform cosmetic/aesthetic procedures?..... Yes No
If yes, please attach list of procedures performed.
- jj. Pain Management procedures? If yes, please attach list Yes No
- kk. Cardioversion (chemical or electrical) Yes No
- ll. Arterial Lines/Arterial Punctures? Yes No

9. Are you engaged in emergency practice? If so, where? _____ Yes No

10. Are you a member of an emergency room team? Yes No

11. Do you render emergency room care other than as a requirement for staff privileges? Yes No

If yes, number of hours per week _____

12. Do you perform procedures in an ICU/CCU/NICU unit? (other than to maintain staff privileges) Yes No

13. Are you in active U.S. Military Service? Yes No

14. a. Medical, Dental or Nursing School: _____ Country: _____ Degree: _____ Year: _____
 b. Served internship at: _____ Country: _____ Year: _____
 c. Served residency at: _____ Country: _____ Year: _____
 d. Are you Board Certified () Yes () No Specialty _____ Year: _____
 e. Are you Board Eligible () Yes () No Specialty _____ Year: _____
 f. Are you a foreign medical or dental school graduate? Yes No
 If "yes," please provide: Year _____ Name of certifying school or organization _____

15. Are you licensed, registered or certified to practice your profession in the State of Texas? Yes No

16. Has your license, authority or privileges ever been revoked, cancelled or suspended? Yes No
 If yes, please submit a copy of the details issued by the state licensing board.

17. Has any claim or suit for any alleged malpractice been brought against you within the past seven years resulting in an indemnity payment? Yes No

WE REQUIRE A COPY OF A CURRENT SELF-QUERY FROM THE NATIONAL PRACTITIONER DATA BANK OR A CURRENT VALUED LOSS RUN FROM THE PRIOR CARRIER(S) COVERING AT LEAST THE LAST SEVEN YEARS. THIS IS A MANDATORY REQUIREMENT. COVERAGE WILL NOT BE BOUND WITHOUT THIS INFORMATION.

18. Are you a partner/stockholder/owner in any of the following?
 a. Medical Partnership Yes No
 b. Professional Association Yes No
 c. Corporation Yes No
 d. Facility or Institution Yes No

If "yes," please give complete name of organization and list of all members:

Name of organization: _____

Name of member doctors	Specialty	Insurer	Limits
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

e. Do you desire Coverage for your Partnership, Professional Association, Corporation, Facility or Institution? Yes No
 If yes, attach a copy of the Partnership Agreement, Articles of Association or Incorporation.

f. If a single member Professional Association, do you desire a separate policy with separate limits of liability at an additional charge of 20%? Yes No

19. Do you (or does your Partnership/Professional Association/Corporation, Facility or Institution) employ, contract or share space with any of the following for professional service:

a. Licensed physicians, surgeons, podiatrists, dentists, pharmacists, optometrists, chiropractors or perfusionists? Yes No

If "yes," give full details below and submit evidence that each carries individual medical (professional) liability insurance with limits of at least \$100,000. each occurrence, \$300,000. aggregate per annum. **SELF INSURED PROGRAMS ARE NOT ACCEPTABLE. THIS IS A MANDATORY REQUIREMENT. NONCOMPLIANCE RENDERS YOU INELIGIBLE FOR COVERAGE.**

Name	Specialty	Performs IV/IM Sedation?	Performs General Anesthesia ?	Performs Invasive Procedures ?	Performs Shock Therapy?	Performs Minor Surgery?	Performs Major Surgery?
_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no

b. Physician's or surgeon's assistants? Yes No If Yes, how many? _____

c. Licensed or certified technicians?

- 1. Radium, diagnostic, x-ray, laboratory, pathological or other? Yes No If Yes, how many? _____
- 2. Radiation therapy? Yes No If Yes, how many? _____
- 3. Certified Registered Nurse Anesthetists? Yes No If Yes, how many? _____
- 4. Certified Nurse Midwife – Births? Yes No If Yes, how many? _____
- 5. Certified Nurse Midwife – No Births Yes No If Yes, how many? _____
- 6. Nurse (Registered) Practitioner? Yes No If Yes, how many? _____

20. Are you employed, contracted or share space with another physician, surgeon, dentist, podiatrists, pharmacists, optometrists, chiropractor or perfusionist?

If yes, please provide name: _____ Yes No

21. Record of Previous Insurance carrier for past three years:

	Name of Company	Policy No.	Period of Coverage	Premium
a.	_____	_____	to	\$ _____
b.	_____	_____	to	\$ _____
c.	_____	_____	to	\$ _____
d.	Expiration date of current coverage _____			

22. **MINIMUM DEPOSIT REQUIRED:** Payment of the Minimum Deposit must be made by CASHIER'S CHECK, BANK DRAFT or POSTAL MONEY ORDER payable to the Texas Medical Liability Insurance Underwriting Association and must accompany this application. When two or more classifications apply, the deposit premium for the highest rated shall be submitted. It is agreed that the remainder of the annual premium and policyholder's stabilization reserve fund charge will be paid within (20) days after receipt of the ASSOCIATION'S billing. Failure to make this payment within such period of time will result in cancellation of any policy (or policies) bound or issued pursuant to this application. Coverage will not be bound by the ASSOCIATION prior to the receipt of the minimum deposit.

For renewal of a JUA expiring policy the full estimated renewal premium plus the Policyholders Stabilization Reserve Fund Charge quoted must be submitted with the application.

23. A POLICYHOLDER'S STABILIZATION RESERVE FUND CHARGE will be collected, when required, on all policies with an effective date on or after JANUARY 1, 1978. This charge was authorized by H.B. 1048 of the 65th legislature.

24. It is understood that the ASSOCIATION'S Manager may designate an Insurance Company to issue and service the policy on behalf of the ASSOCIATION. The undersigned agrees:

- a. To comply with all reasonable rules of the Servicing Company for the prevention of injuries
- b. To furnish the Servicing Company promptly with any Report of Injury
- c. To furnish all other forms and information required by the terms of the policy
- d. To maintain adequate records in order that an accurate audit may be made by the Servicing Company.
- e. To pay as due all monies for premium under such policy, including the policyholder's stabilization reserve fund charge, to the Servicing Company provided, however, that in the event of default on payment of any premiums or other charges due under any policy issued as a result of this application all premiums and other charges due and unpaid shall become payable at the office of the Texas Medical Liability Insurance Underwriting Association, Austin, Travis County, Texas, and the undersigned hereby promises and agrees to pay all such premiums at the office of the ASSOCIATION. I further agree that there are no unpaid premiums or other charges due this Association from prior insurance of the type applied for.
- f. That no insurance coverage will be considered bound until applicant has received a Binder duly executed by the Manager of the ASSOCIATION and such insurance shall become effective from the date and time specified by the ASSOCIATION Manager.

25. Is this policy being financed by a premium finance company? Yes No

If yes, the finance agreement must be issued in the name of the insured as it appears on the policy, and we must receive a complete copy of the signed finance agreement. The use of outside financing does not change any payment requirements stated above or in any renewal notification.

IMPORTANT: THIS APPLICATION AND RELEASE MUST BE SIGNED BY THE APPLICANT

The foregoing statements are made by applicant as material representations of fact for the purpose of showing that he/she is in good faith entitled to insurance as a rejected risk and securing approval of this application, and such statements are true and correct. It is understood that the underwriting data on this application may be made available to all Member Companies of the ASSOCIATION.

I authorize and consent to investigations in respect of material information bearing upon moral character, professional reputation and fitness to engage in the activities embraced by my license or authority to practice my profession, including authorization to every person or entity, public or private, to release to the ASSOCIATION any documents, records or other information bearing upon the foregoing.

Date	#	LICENSE NUMBER (Medical, Dental, Other)	Signature of Applicant
Telephone Number		Fax Number	Print Name

STATE OF TEXAS LOCAL RECORDING AGENT KNOWN AS PRODUCER OF RECORD

As Producer of Record, I certify that the information relating to rating and classifications as shown and all other answers and data given above, are true and correct to the best of my knowledge and belief and that I am a licensed Texas Local Recording Agent.

Name of Producer of Record (Type or Print)	Producer's Federal Income Tax Identification Number
Street Address	Telephone Number
	Fax Number
City	State
	Zip
Email address of Customer Service Representative	Signature of Producer of Record
	Email address of Agency or Producer