



American Medical Massage Association

Membership Application

Healthcare is in your hands



CONTACT DATA

Full Name (First, Middle, Last)		Practice / Clinic Name		
Office or Mailing Address (include Suite #)		City	State	Zip
Office Phone	Alternate Phone (Home, Cell, etc.)	Fax	Email	
<input type="checkbox"/> Practitioner	Message School Attended (Students provide School attending and expected completion info)		Graduated	Hours Completed
<input type="checkbox"/> Student				

PROFESSIONAL INFORMATION (Students Skip to Question 9)

1. Is your Massage license issued by: State City N/A Is your Massage license current? (Attach Copy) Yes No
2. Has any malpractice claim or proceeding ever been brought against you, your associates or employees, or are you aware of any circumstance that could give rise to such a claim? (If YES, attach explanation) 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 massage 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. Do you provide any Massage service other than as taught in the Massage schools and colleges? (If YES, explain) Yes No
9. When do you want your Massage insurance to be in effect (may not be before date app is received)? _____
10. List other health professions you are licensed to practice (RN, LMT, LAc, etc.) Separate coverage is required: _____
11. Additional Insured - If you have a corporation or a partnership we recommend you add that entity as an additional insured. Your landlord, employer, or school may also require additional insured status. For each additional insured provide the following. Add sheets as needed:

Entity Name	Address
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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 AMMA Pac.

<input type="checkbox"/> Professional	@ \$249 =	
<input type="checkbox"/> Student	@ \$199 =	
<input type="checkbox"/> Fellowship	@ \$100 =	
<input type="checkbox"/> Association Affiliate	@ \$50 =	
<input type="checkbox"/> Additional Insured	@ \$10 =	
TOTAL AMOUNT DUE:		

Check
 Mastercard
 Visa
 Discover
 AMEX

Card #: _____ Expires: _____

SIGN THEN FAX OR MAIL APPLICATION

I hereby apply for membership and / or coverage. 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 AMMA membership. I understand untrue statements could void my policy and / or my AMMA 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