# CHIROPODIST/PODIATRIST SUPPLEMENT
## Forming part of the Professional Liability Application

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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 <u>excluding</u> 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