AOM INSURANCE AND RISK MANAGEMENT PROGRAM
Professional Liability Insurance Application Form
New Registrants

IDENTIFICATION

1. Name of Applicant:

2. Name of Midwifery Practice Group:

3. a) Practice Address:

   b) Geographical Area of Practice (Catchment Area):

PROFESSIONAL BACKGROUND

4. Please confirm that you have applied for registration with the College of Midwives of Ontario.
   ☐ Yes ☐ No If no, please explain:

5. Have you ever been disciplined by a health professions licensing body, such as the College of Midwives of Ontario, or its equivalent in another jurisdiction?
   ☐ Yes ☐ No If yes, please provide details:

6. List all hospitals or birthing centres where you currently have privileges and/or are planning to apply for privileges.

Hospital/Birthing Centre	City

INSURANCE HISTORY

7. Has Professional Liability Insurance coverage ever been declined or cancelled or the renewal thereof been refused to you?
   ☐ Yes ☐ No If yes, please provide details:

CLAIMS HISTORY

8. a) Have you ever been the recipient of allegation(s) of professional negligence either in writing or verbally?
☐ Yes ☐ No If yes, please provide details:

b) Have you ever been named in a lawsuit, grounded or not, arising out of your professional activities?
☐ Yes ☐ No If yes, please provide details:

For information on submitting an incident report, please contact midwives@hiroc.com or 1-800-442-7751 or Allyson Booth at the AOM at allyson.booth@aom.on.ca or 1-866-418-3773.

9. Are you aware of any facts, circumstances, or situations, which may give rise to an allegation(s) of professional negligence?

☐ Yes ☐ No If yes, please provide details:

WITHOUT LIMITATION OF ANY OTHER REMEDY AVAILABLE TO THE INSURER, IT IS AGREED THAT IF THERE BE KNOWLEDGE OF ANY SUCH FACT, CIRCUMSTANCE, OR SITUATION, ANY CLAIM OR ACTION SUBSEQUENTLY EMANATING THEREFROM IS EXCLUDED FROM COVERAGE UNDER THE PROPOSED INSURANCE.

DECLARATION AND SIGNATURE

I declare that to the best of my knowledge, the statements set forth herein are true and further agree that if any significant change is discovered between the date of this application form and the effective date of the policy, which would render this application form inaccurate or incomplete, notice of such change will be reported immediately in writing to the Insurer. Signing this application does not bind the Applicant or Insurer to complete the insurance, but it is agreed that this form shall be the basis of the contract should a policy be issued and this form will be attached to and become part of the policy.

Date:	Signature of Applicant:

PLEASE FULLY COMPLETE AND RETURN THIS FORM TO THE MEMBERSHIP DEPARTMENT AT THE ASSOCIATION OF ONTARIO MIDWIVES BY:

Email: membership@aom.on.ca
-or-
Fax: 416-425-6905