



**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.  
Policy Year: May 31, 2018 to May 31, 2019

Hospital/Birthing Centre	City	% of Practice	List Names of Midwives if not Entire Practice Group

**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](mailto:midwives@hiroc.com) or 1-800-442-7751 or Allyson Booth at the AOM at [allyson.booth@aom.on.ca](mailto: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:**

**ASSOCIATION OF ONTARIO MIDWIVES  
365 BLOOR STREET EAST, STE 800  
TORONTO ON M4W 3L4**