



Date of Application: _____

IDENTIFICATION/ADMINISTRATION

- 1. Legal First Name: _____
- 2. Legal Middle Name: _____
- 3. Legal Last Name: _____
- 4. AKA name: _____
- 5. Née Name (if applicable): _____
- 6. Registration/License No. _____
- 7. Office Telephone: _____
- 8. Cell: _____
- 9. Business E-mail*: _____
- 10. Alternate E-mail: _____
- 11. Mailing Address _____

**Business E-mail – email also used for username to access HIROC website.*

12. Please select the applicable current status:

Full-time Part-time Casual/Locum

Indigenous

Special Arrangement – Please describe:

Other _____



PRACTICE GROUP (OR EMPLOYER)

1. Legal Name (and/or numbered company) of Primary Midwifery Practice Group that you are affiliated with:

2. Operating Name of Practice Group:

3. Practice Address:

4. City & Postal Code:

If you are part of more than one Practice Group, please attach information.

PROFESSIONAL INFORMATION AND AFFILIATIONS

MEMBERSHIPS AND AFFILIATIONS

1. Are you a member in good standing with the Provincial Regulatory Body? Yes No

2. Have you ever been involved in a regulatory body investigation resulting in a referral to a disciplinary or quality committee, and/or a decision of a regulatory body affecting the applicant's licensure/registration? Yes No

3. Has voluntarily or involuntarily relinquished any professional license or registration, terminated midwifery membership or have their clinical privileges restricted, reduced or removed? Yes No

4. Are you a member of other professional associations or licensing bodies?
Please name the associations and licensing bodies of which you are a member.

5. Do you have an affiliation agreement with schools whose students come for you to training? Yes No



PROFESSIONAL INFORMATION AND AFFILIATIONS

Continued...

PROFESSIONAL PREPARATION AND IMPROVEMENT

1. List any conferences or seminars attending in the past year.

Four horizontal lines for text entry.

2. List any courses completed in the past year related to Midwifery.

Four horizontal lines for text entry.

MIDWIFERY CASELOAD

1. Number of courses of care attended by you as the principal midwife for previous year (April 1 to March 31)?

Horizontal line for text entry.

2. Number of courses of care anticipated by you as the primary midwife for previous year (April 1 to March 31)?

Horizontal line for text entry.

3. Please provide the number of non-resident of Canada clients for previous year (April 1 to March 31).

Horizontal line for text entry.

4. Do you consistently obtain a signed Governing Law and Jurisdiction forms ("GLJA") from each non-resident of Canada client?

Yes

No



INSURANCE/CLAIMS HISTORY

- 1. Has Professional Liability Insurance coverage ever been declined or cancelled or the renewal thereof been refused to you? Yes No
- 2. Have you ever been the recipient of allegation(s) of professional negligence either in writing or verbally that is not known to HIROC? Yes No
- 3. Have you been named as a defendant in any civil legal action arising from your professional conduct, competence or capacity, including whether the claim is resolved or judgment rendered. Yes No
- 4. Have you ever been found liable in any Canadian or International court of competent jurisdiction as a result of a breach of the standard of care, professional misconduct, etc.? Yes No
- 5. Have you ever been charged or convicted with a criminal offence in Canada or internationally, including the reason? Yes No
- 6. Are you aware of any facts, circumstances, or situations, which may give rise to an allegation(s) of professional negligence that is not known to HIROC? Yes No

If **yes** to questions 1 -4 please send a written report providing details directly to HIROC – newclaims@hiroc.com.

If you have provided information in the past please state that it has been documented, to whom and the year (i.e. #16 – Document on file with the Name of Lawyer, or HIROC, 2012).

APPLICANT ADDITIONAL NOTES

Empty box for applicant additional notes.



DECLARATION AND SIGNATURE

PLEASE READ DECLARATION PRIOR TO SIGNING

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.

Signature of Applicant: Click to enter name

Date: Click here to enter a date.

FOR ASSOCIATION/REGULATORY USE ONLY

PAYMENT DETAILS

Please complete the form and send electronically (if there is an electronic signature) to the Association, with a copy to midwives@hiroc.com.

Payment Options:

- 1. Electronic – Paypal: You may pay \$AMOUNT to INSERT NAME at www.paypal.com. Please note that a \$AMOUNT fee is included for this payment option.
2. Bank Draft or Canadian Money order payable to the INSERT NAME for \$AMOUNT to be sent via mail or courier:
• Name of contact, title
Organization insuring Midwives

PAYMENT PENALTY

Member Who does not make Payment by INSERT DATE

Any member who does not make payment for liability insurance by INSERT DATE will be subject to a \$XXX penalty fee. Insurance renewal will also be delayed until such fees have been received.

MEMBER CONTACT DETAILS AND STATUS CHANGES

Members Responsibility – Contact Details

Members are also responsible to notify ASSOCIATION CONTACT EMAIL and midwives@hiroc.com if any change of contact information. The ASSOCIATION NAME is not responsible for any members who fail to update the Association with current contact details.

Members Changing Status at any time of year

Please ensure that you inform the ASSOCIATION NAME if your status changes at all during the year. Note if you are on leave for less than 60 days your insurance remains in place.



Professional Liability Insurance Application



FOR ASSOCIATION/REGULATORY USE ONLY

Registration/License No.

Registration Date:

[Click here to enter a date.](#)

Registration Class:

Full-Time

Part-Time

I confirm that the above applicant has been registered with the **PROVINCIAL REGULATORY BODY**

Signature of ASSOCIATION NAME Staff:

Date: [Click here to enter a date.](#)