ROBERT A. SCHNEIDER AGENCY, INC.

Minnesota
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MASSAGE THERAPY SUPPLEMENT

NAME OF INSURED:____

1. Year in business: _________
   If a new venture, number of years experience in this field: ________

2. Number of employees, NOT INCLUDING OWNER: __________

3. Payroll, NOT INCLUDING OWNER: _______________

4. Percentage of work performed on the applicant's own premises: ___________

5. Percentage of work performed on the premises of other's as an independent contractor:

6. If the applicant is indep.contr., list employers:

____
____
____

7. Is applicant licensed as required by the state: Yes or No

8. Are you the graduate of a training program accredited or approved by the Commission on Massage Therapy Accreditation (COMTA) or are you certified by the Nat'l Certification Board of Theraputic massage & Bodyworks? Yes or No

9. Where did you receive your training? ______________________________________

10. How many hours of training did you complete? ______________________________

11. Did you have advanced training in any specific techniques? Yes or No

12. Are you a member of AMTA? Yes or No

13. Does massage for relaxation therapy only: Yes or No

14. Works in Sports Medicine: Yes or No

10. Works as a physical therapists: Yes or No

11. Has clients signs waivers: Yes or No

If Yes, please provide copy

<u>PLEASE Note :</u> We EXCLUDE Communicable Disease & Abuse & Molestation