



Health & Fitness Application

Submission #

18757 Burbank Blvd, #104, Tarzana, CA 91356
Phone: (818)996-0900
www.certifiedtrainerinsurance.com

Send Completed Application to: Fax: (818) 279-6999 or Email: Derek@kulchinross.com

BASIC INFORMATION

Proposed Effective Date:
Named Insured: DBA:
Mailing Address:
Primary Contact Name: Business Phone: Home Phone:
Cell Phone: Fax: Email:
Secondary Contact Name: Business Phone: Email:
Website Address:
How did you hear about our program? Email Internet Mailing Referral Seminar Other
Experience: Health Club Management Business Experience in the Health & Fitness Industry
Health/Fitness Degree or Certification Other Business Experience
Current Carrier & Limits of Liability:
Is this policy being non-renewed? Yes No Expiring Premium:
If so, why? Carrier no longer writing this coverage Loss History Other

LIABILITY LIMITS & COVERAGE

General Liability (Including Professional Liability) Limit (choose one):

\$1,000,000/ \$2,000,000 \$1,000,000/ \$3,000,000 \$2,000,000 / \$4,000,000

Abuse Liability Limit :

\$100,000/\$300,000 \$500,000/\$1,000,000 \$1,000,000/\$2,000,000 \$1,000,000/\$3,000,000

Fire Damage Legal Liability (Damage To Premises Rented To You) Limit :

\$300,000 \$500,000 \$1,000,000 \$1,500,000 \$2,000,000

Medical Payments Coverage:

\$0 \$5,000 \$10,000

Stop Gap Limit (Available in ND, OH, WA, WY only)(choose one):

\$100,000 / \$500,000 / \$100,000 \$500,000/\$500,000/\$500,000 \$1,000,000/\$1,000,000/\$1,000,000

Employee Benefits Liability: Retroactive Date Number of employees per location

Limit (choose one): N/A \$500,000 / \$1,000,000 \$1,000,000/\$2,000,000

Hired Non-Owned Auto Liability Limit: (Only available if you do not have any owned autos)

N/A \$500,000 \$1,000,000

BUSINESS INFORMATION

Form of Business: Corporation Individual Partnership Joint Venture LLC

Are you a member of a franchise? Yes No

Date business started under current ownership:

SERVICES

Location # _____

Address: _____

What services do you provide at this location? (Services with an * require the completion of a supplemental application)

- Group Exercise Classes/ Spinning Classes/ Aerobics Classes
Kick Boxing Classes
Saunas
Ropes Course*
Dance Classes
Yoga Classes
Steam Room
Personal Training
Free weights/ Selectorized Equipment
Rock Walls*
Day Spa*
Batting Cages*
Martial Arts*
Zip Line*
Hiking**
Cross Country Skiing**
Boot Camps**
Indoor Golf**
Marathons**
Outdoor Cycling**
Children's Parties**
Cross Fit
Water Parks*
Internet Counseling**
Children Summer Camp Programs**
Tumbling Classes
Wedding Receptions**
Massage Therapy - How many treatment rooms?
Estimated Number of Therapists:
Tanning Beds / Booths* - How Many:
Soccer - How many leagues?
Tennis - How Many Courts:
Physical Therapy
Racquetball/Squash - How Many Courts:
Employee How many?
Basketball - How Many Courts:
1099 Contractor How many?
Other (including outside activities):
Nutritionist
Employee How many?
1099 Contractor How many?
Hypnotherapist
Employee How many?
1099 Contractor How many?
Chiropractor
Employee How many?
1099 Contractor How many?
Child Sitting - Are parents/guardians required to be on premises while the child is in your care?
Bounce House
Are there signs clearly marking age, height or size limitations?
Are they inspected by the state and/or you and your employees?
Do you use the manufacturer's checklist for the set up & use of the equipment?

Services with ** require an explanation Please explain: _____

Please advise if any spaces in your facility are dedicated to the following activities:

- Video Sales or Retail Sales
Laundry Facility
Warehouse - Square Footage of the Warehouse:
Liquor Sales - Percentage of receipts from food/liquor service:
Food Service - Type of Services: Full-service Restaurant
Snack/Juice Bar
Vending Machines
Do you have any of the following: Deep Fryer
Grill
Ansul System

Annual receipts from Food/Liquor Service: _____

Submission # _____

Health & Fitness Application

(A Copy of this Page is Required for Each Additional Location)

OPERATIONS

Location # _____

Address: _____

Which best describes the operations at this location:

- 24/7 Fitness Center Athletic Club Barber Shop Beauty Salon Corporate Fitness Center Dance Studio
- Day Spa Fitness / Studio Full Service Health/Fitness/Spa Health/Fitness Club/Spa Martial Arts Studio
- Massage Center Nail Salon Personal Trainer Studio Pre-sales / Office Yoga, Pilates or Aerobic Studio
- Non Profit Community Center

Annual Revenue (excluding Food Services): _____ Number of Active Members: _____ Square Footage: _____

Do you have a liquor license? Yes No If yes, do you want Liquor Liability Coverage? Yes No

Does this location have any pools, spas, whirlpools, jacuzzi's or hot tubs? Yes No If yes, complete pool supplemental

Do you have any office space at this location? Yes No Square Footage: _____

Do you lease space to others at this location? Yes No Total Square Footage: _____

Tenant: _____ Square Footage: _____ Tenant: _____ Square Footage: _____

Tenant: _____ Square Footage: _____ Tenant: _____ Square Footage: _____

Are Employees/Owners present during all hours of operation? Yes No If no, complete 24 hour access supplemental

Are the clientele at this facility primarily children under the age of 18? Yes No

Digital surveillance is in place and operational at all times? Yes No

Do you have Automatic External Defibrillators on site? Yes No

ADDITIONAL INSURED

List all additional insureds that need to be listed on the policy:

Name: _____

Address: _____

Insured Type: Designated Person Franchisor Leaser of Equipment Landlord

Name: _____

Address: _____

Insured Type: Designated Person Franchisor Leaser of Equipment Landlord

Name: _____

Address: _____

Insured Type: Designated Person Franchisor Leaser of Equipment Landlord

Name: _____

Address: _____

Insured Type: Designated Person Franchisor Leaser of Equipment Landlord

Name: _____

Address: _____

Insured Type: Designated Person Franchisor Leaser of Equipment Landlord

Name: _____

Address: _____

Insured Type: Designated Person Franchisor Leaser of Equipment Landlord

Submission #

Health & Fitness Application

(A Copy of this Page is Required for Each Location for which property coverage is desired)

BASIC PROPERTY INFORMATION

Location #: _____ Building #: _____

Address: _____

Property Deductible (choose one): \$500 \$1,000 \$2,500 \$5,000 \$10,000 \$25,000 \$50,000 \$75,000

Wind/Hail Deductible (choose one): Same as all other property Exclude

Percent - 2% 5%

Flat \$1,000 \$2,500 \$5,000 \$10,000 \$25,000 \$50,000 \$75,000

Property Coinsurance Percentage (choose one): 80% 90% 100%

Construction Type (choose one): Frame Joisted Masonry Masonry Non-Combustible

Non-Combustible Semi-Fire Resistive Fire Resistive

Is your building sprinklered? Yes No

In what year was the building constructed? _____

If the building is more than 20 years old, insert the year of the latest building updates completed for each category:

Plumbing: _____ Heating: _____ Roof: _____ Electrical: _____

What type of Alarm system is in the building? None Burglar Alarm Fire Alarm Both

Number of Stories: _____

COVERAGES AND LIMITS

Choose the coverages desired or are required to carry:

Building \$ _____ Replacement Cost ACV Inflation Guard _____

Business Personal Property \$ _____ Replacement Cost ACV

Tenant Improvements & Betterments \$ _____ Replacement Cost ACV

Signs (\$1,000 Deductible) \$ _____

Description of sign(s): Attached Free Standing Both

Type of sign(s): Entirely Metal Other

Business Income (72 Hr Wait Period) \$ _____

Does a separate business income coinsurance apply? Yes No

If so, please choose one: 50% 60% 70% 80% 90% 100% 125%

Select the monthly limit of indemnity: 1/3 1/4 1/6 None

PROPERTY ADDITIONAL INTERESTS

List all property additional interest that need to be listed on the policy:

Name: _____

Address: _____

Insured Type: Mortgagee Building Owner Loss Payee Lender's Loss Payee

Name: _____

Address: _____

Insured Type: Mortgagee Building Owner Loss Payee Lender's Loss Payee

For Inland Marine or Crime Coverages, please complete the appropriate Accord application and submit with the completed Health & Fitness Application

Health & Fitness Application
QUALIFICATION

Do you have a formal safety program? No Yes

Any policy or coverage declined, cancelled or non-renewed during the prior 3 years? N/A in Missouri No Yes

Have any crimes occurred or been attempted on your premises within the last 3 years? No Yes

Are you currently in bankruptcy? No Yes

Do you conduct orientation for all new members? No Yes

Do you require signed waivers from all clients? No Yes

Is safety signage used throughout the facility? No Yes

Do you have non-slip surfaces in ALL wet areas? No Yes

Do you have showers in your facility? No Yes

Do you keep equipment maintenance logs? No Yes

Do you manufacture, formulate, private label your own products? (lotions, supplements, equipment, etc.) No Yes

**Coverage is only provided for skin care products. no coverage is provided for any ingested products.

Do you use independent contractors? No Yes

If so, do you require proof of independent contractor's insurance? No Yes

What limits do you require? _____

LOSS HISTORY

List all losses in the past 3 years whether or not insured(Attach additional sheet if necessary):

Date of Claim	Type of Claim	Description of Claim	Open/Closed	Paid

I AM AWARE THAT THE COMPANY MAY ORDER AN INSPECTION FOR MY PLACE OF BUSINESS AND I AGREE TO COOPERATE WITH THE INSPECTOR(S).

FRAUD WARNINGS

GENERAL FRAUD STATEMENT (not applicable in Colorado, Florida, Hawaii, Massachusetts, Nebraska, Ohio, Oklahoma, Oregon and Vermont) Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and (NY: substantial) civil penalties. In the District of Columbia, Louisiana, Maine, Tennessee and Virginia, and Washington insurance benefits may also be denied.

NOTICE TO COLORADO APPLICANTS: THIS NOTICE IS A PART OF YOUR APPLICATION FOR PROFESSIONAL LIABILITY INSURANCE: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

NOTICE TO FLORIDA APPLICANTS: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

NOTICE TO HAWAII APPLICANTS: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: A person who knowingly and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO OREGON APPLICANTS: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact, may be violating state law.

NOTICE TO VERMONT APPLICANTS: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, may be committing a crime, subjecting the person to criminal and civil penalties.

THE APPLICANT DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE APPLICANT AGREES THAT IF THE INFORMATION SUPPLIED ON THE APPLICATION BY THE APPLICANT CHANGES BETWEEN THE DATE OF THE APPLICATION AND THE EFFECTIVE DATE OF INSURANCE, APPLICANT WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS AND/OR AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

Applicant's Signature: _____ Date: _____

Producer's Signature: _____ Date: _____
(Only applicable if using a producer)

Producer's License Number: _____ Exp. Date: _____

Health & Fitness Application
24 Hour Access Supplement
(A Copy of this Page is Required for Each Location)

Submission # _____

Location #: _____

Address: _____

Do members have key/swipe cards access to facility? No Yes

Do you have a panic system that is monitored by an outside source and was installed as recommended by the vendor? No Yes

If yes, which type of panic system do you have? Hardwired and wall mounted Emergency Necklaces

Are all unauthorized areas of the club locked off with only access to those areas during normal business hours? No Yes

Do you physically inspect the club several times a day to verify unsafe conditions have not developed? No Yes

Do you prohibit the use of the facility from any uninsured personal trainer? No Yes

Do you have specific separate waivers? No Yes

Applicant's Signature: _____

Date: _____

Health & Fitness Application
DaySpa Supplement
(A Copy of this Page is Required for Each Location)

Submission # _____

Location #: _____

Address: _____

Number of treatment rooms: _____

Square Footage: _____

Do you have any licensed Cosmetologists? Yes No

If yes: Number of W2 employees: _____ Number of 1099 Independent Contractors: _____

Do you have any licensed Estheticians? Yes No

If yes: Number of W2 employees: _____ Number of 1099 Independent Contractors: _____

Do you have any other licensed professionals? Yes No Describe: _____

If yes: Number of W2 employees: _____ Number of 1099 Independent Contractors: _____

SERVICES

Indicate all services provided at this location

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Airbrush Tanning | <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Hydrotherapy | <input type="checkbox"/> Oxygen Bar |
| <input type="checkbox"/> Airbrush Tattooing | <input type="checkbox"/> Ear Piercing | <input type="checkbox"/> Low Acid Peels | <input type="checkbox"/> Pulse Light Therapy |
| <input type="checkbox"/> Aromatherapy | <input type="checkbox"/> Endermology | <input type="checkbox"/> Lymphatic Drainage | <input type="checkbox"/> Skin Care/Facials |
| <input type="checkbox"/> Aquamassage | <input type="checkbox"/> Endothermology | <input type="checkbox"/> Make-Up Application/Lesson | <input type="checkbox"/> Sugaring |
| <input type="checkbox"/> Beauty Products Sold | <input type="checkbox"/> Foot Therapy (Detoxification) | <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Vichy Shower |
| <input type="checkbox"/> Cellulite Treatment | <input type="checkbox"/> Hair Services | <input type="checkbox"/> Muscle Electro-Stimulation | <input type="checkbox"/> Waxing |
- Body Wraps - What type of wraps? _____
- Manicure/Pedicure - Do you do fish pedicures? Yes No
- Microdermabrasion - Do you go below the dermal layer? Yes No
- Teeth Whitening - At home kits sold LED lights used Trays Used

SAFETY QUESTIONNAIRE

Do independent contractors or booth renters conduct operations on your premises? Yes No

Are the work areas where acrylics are used well ventilated? Yes No

Are all employees instructed in first aid to potential eye contamination by chemicals? Yes No

Are all body contact supplies sanitized after each use? Yes No

Are toxic chemicals stored from access to customers? Yes No

Do you manufacture or repackage any products? Yes No

Are any products manufactured and distributed under your private label? Yes No

If yes, please describe the product and attach proof of manufacturers coverage: _____

Do you have any procedures that require needles? Yes No

Exclusions: Acupuncture, permanent tattooing, permanent make-up, electrolysis, laser hair removal, chiropractic, ear candling and any invasive procedures or techniques including but not limited to collagen injections and colon cleansing procedures.

Applicant's Signature: _____

Date: _____

Submission # _____

Health & Fitness Application
Martial Arts Supplement
(A Copy of this Page is Required for Each Location)
MARTIAL ARTS PROGRAM INFORMATION

Location #: _____

Address: _____

Number of students in all programs: _____

Types of Martial Arts taught:

- | | | | |
|---|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Aikido | <input type="checkbox"/> Jeet Kune Do | <input type="checkbox"/> Krav Maga | <input type="checkbox"/> Wushu |
| <input type="checkbox"/> Brazilian Jiu Jitsu | <input type="checkbox"/> Judo | <input type="checkbox"/> Kung Fu | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Capoeira | <input type="checkbox"/> Karate | <input type="checkbox"/> Shaolinquan | |
| <input type="checkbox"/> Chi Kun | <input type="checkbox"/> Kenjitsu | <input type="checkbox"/> Tae Kwon Do | |
| <input type="checkbox"/> Fitness Boxing (non-contact) | <input type="checkbox"/> Kick Boxing - | <input type="checkbox"/> Tai Chi | |
| <input type="checkbox"/> Goju-ryu | <input type="radio"/> Cardio/Fitness Only | <input type="checkbox"/> Tai ju quan | |
| <input type="checkbox"/> Hapkido | <input type="radio"/> Contact/Sparring | <input type="checkbox"/> Tang Soo Do | |

SAFETY AND TRAINING INFORMATION

Level of contact: Non Contact Light Contact Full Contact

What is the belt rank of the owner or primary instructor? _____

Is protective equipment provided to all participants? Yes No

Is weapons training provided? Yes No

If yes, are padded or fake weapons the only type used? Yes No

If no, please describe program and weapons used in detail: _____

Do you practice sparring? Yes No

If yes, is an instructor present at all times? Yes No

Do you participate in tournaments? Yes No

Hosted tournaments are those you organize and operate that include participants who are not members of your school or organization.

How many "hosted tournaments" do you do per year? _____

Approximately how many participants are at each tournament? _____

Are they held at your school/club? Yes No

If not, do you lease/rent other space to sponsor the tournament? Yes No

If so, where? _____

Note: You should require proof of medical payments for participants coverage being in place for all non-registered members/participants taking part in your hosted tournament.

Ineligible Operations

Boxing (contact/sparring) - Dim Kam - Haganah - Kali/escrima - Mixed Martial Arts (MMA)
Ultimate fighting/Extreme fighting/Cage fighting - Savate - Sayoc Kali - Thai Boxing/Muay Thai
Training programs for law enforcement - Public Safety and Militray Personnel - Unsupervised Wrestling

Applicant's Signature: _____

Date: _____

Health & Fitness Application
Waterpark Supplement
 (A Copy of this Page is Required for Each Location)

Submission # _____

Location #: _____

Address: _____

How are water elements secured in the off-season? _____

When are inspections performed? Daily Weekly Monthly Annually

Is there a periodic inspection done by an independent inspector? No Yes

If yes, by who? _____

Number of Lifeguards: _____

Lifeguards trained and certified by: Ellis & Associates American Red Cross Other: _____

Employees licensed or certified by the state? No Yes

Are hazardous or toxic materials stored on premises? No Yes

If yes, please explain how and where: _____

ATTRACTIONS

Slides

Type of Slide	Name	# of Flumes	Kind of finish	length	width	Built on		# of attendants	
						hill	stilts	top	bottom
						<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
						<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
						<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
						<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
						<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Is anything used to assist the participants in going down the slide? No Yes

If yes, identify the slide(s) and what is used: _____

Landing Areas

Kind of Landing Area:			Depth	Area	Water Level of Landing Area:			
Pool	Lake	Other			(Describe)	Above end of flume	even with end of flume	below end of flume
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Attractions

Please include all other water attractions (i.e. wave pools, kiddie pools, swimming pools, diving boards, lakes, streams, as well as non-water attractions such as play areas, picnic areas, etc)

Description (include height & width if applicable)	Manufacturer	Serial Number (if any)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Applicant's Signature: _____

Date: _____

Health & Fitness Application
Pool/Spa Supplement
(A Copy of this Page is Required for Each Location)

POOL/SPA INFORMATION

Submission # _____

Location #: _____

Address: _____

How many of each pool type do you have?

Spa Pool / Jacuzzi / Hot Tub How many? _____

Lap Pool How many? _____ Deepest Area: _____

Recreation Pool How many? _____ Deepest Area: _____

POOL/SPA SAFETY INFORMATION

Is the pool/spa compliant with the Virginia Graeme Baker Pool & Safety Act? No Yes

**If no, your fitness center does not qualify for our program.

Are there lifeguards present during all hours of operation? No Yes

Are pool depths marked? No Yes

Do all pool drains and grates have covers that cannot be removed without using a tool? No Yes

Do any of the pools have a diving board? No Yes

If yes, how high? _____

Are there any slides? No Yes

If yes, what type? Open Enclosed Both

If there are open slides, do they exceed 4 feet? No Yes If yes, how high? _____

If there are enclosed slides, do they exceed 6 feet? No Yes If yes, how high from the top level? _____

Are all pools/spas cleaned daily? No Yes

Are all pool / spa chemicals kept in a dry, ventilated, locked storage area? No Yes

Applicant's Signature: _____

Date: _____

Submission # _____

Health & Fitness Application
Rock Wall Supplement
(A Copy of this Page is Required for Each Wall)

ROCK WALL INFORMATION

Location #: _____

Address: _____

Manufacturer of the Rock Wall:

- American Rock Climbing SpectrumSports/Rebound Active Sports
 Vertical Reality Other _____
 Extreme Engineering

What year was the rock wall constructed? _____

Is the rock wall indoors or outdoors? Indoors Outdoors

Height of Wall: _____

Width of Wall: _____

Is the rock wall supervised at all times? No Yes

Is there a formal maintenance checklist? No Yes

Is there a minimum of 6-12 in of fall protection beneath the rock wall out to a distance of 6-8 ft? No Yes

What type of material is used in the landing area? _____

Is there a formal employee safety training program? No Yes

Are safety rules posted? No Yes

TRAINING AND SAFETY INFORMATION

Is there a documented training program for all wall users which includes:

- Harness and rope inspection procedure? No Yes
Proper belaying techniques? No Yes
Emergency take-downs? No Yes
Belay device failure or entrapment? No Yes
Rules for climbing wall? No Yes
Setup and take-down procedures? No Yes
Procedures for reporting a problem? No Yes

Is the tool loop cut off from the safety harness? No Yes

When the rock wall is not in use, how and where do you store it? _____

How often are the cables replaced? _____

Is the rock wall manual or auto belay? Manual Auto

Is there a method to identify approved users prior to their use of the wall? No Yes

Applicant's Signature: _____

Date: _____

Health & Fitness Application
Ropes Course Supplement
(A Copy of this Page is Required for Each Location)

ROPES COURSE INFORMATION

Submission # _____

Location #: _____

Address: _____

Name of Ropes Course	Manufacturer	Vertical or Horizontal	# of Stories

What is your customer age requirement? No one under the age of: _____ No one over the age of: _____

Are there any customer weight restrictions? No one under (lbs): _____ No one over (lbs): _____

Are there any medical restrictions such as heart, pregnancy, or back problems? No Yes

If yes, please describe: _____

Are safety harnesses fitted to the size of the person? No Yes

What type of track system does your ropes course use? Safety Puck Track

What type of safety harness do you use? Chest Harness Quick Harness Full Body Harness

Is there an employee safety line? No Yes

EMPLOYEE INFORMATION

How many employees are used when the ropes course is in operations? _____

Are your employees trained? No Yes

Are all employees that operate the ropes course certified? No Yes

If yes, do you recertify your employees? No Yes

Applicant's Signature: _____

Date: _____

Health & Fitness Application
Tanning Supplement
(A Copy of this Page is Required for Each Location)

Submission # _____

Location #: _____

Address: _____

How is tanning exposure time controlled? User Operator Token

Is protective eye wear provided for customers? No Yes

If yes, is it sanitized after each use? No Yes

Are the tanning beds sanitized after each use? No Yes

Is the maximum exposure time for tanning within manufacturer guidelines? No Yes

Is a drug reaction list posted in your club? No Yes

Do you manufacture your own tanning beds? No Yes

Are all beds UL listed? No Yes

Are customers required to read & sign an acknowledgement of the risks involved with the tanning exposure? No Yes

Applicant's Signature: _____

Date: _____

Health & Fitness Application
Workers' Compensation Supplement
 (A Copy of this Page is Required for Each Location)

Submission # _____

Location #: _____

Address: _____

Employers Liability Limits \$100K/ \$500K/ \$100K \$500K/ \$500K/ \$500K \$1M/ \$1M/ \$1M

Deductible: None Medical Only Indemnity Only Medical and Indemnity

Federal ID Number: _____ State Employer ID Number (MN, NC, & ME only): _____

Current Experience Mod (if any): _____

EMPLOYEES

Classifications	No. Full Time Employees	No. Part Time Employees	Annual Payroll
Employees:			
1099 Contractors			
Other:			

Include owners, officers, proprietors, partners, members of LLC for WC? Yes No If yes, complete the following information:

Full Name	Title	Ownership %	Annual Payroll

GENERAL INFORMATION

- Business own, operate or lease aircraft/watercraft? Yes No
- Is the applicant engaged in any other type of business? Yes No
- Is any work subletted without certificates of insurance? Yes No
- Are you operating without a formal safety plan? Yes No
- Are any employees under 16 or over 65 years of age? Yes No
- Do you lease employees? Yes No
- Do employees travel out of state? Yes No
- Policy canceled or nonrenewed within the last 3 years? Yes No
- Is there any volunteer or donated labor? Yes No
- Is there a labor interchange with any other business/subsidiary? Yes No
- Have you ever been cited by OSHA? Yes No

Please explain any "Yes" answers:

Applicant's Signature: _____

Date: _____