

Name: \_\_\_\_\_  
License No. \_\_\_\_\_

**FINANCIAL RESPONSIBILITY**  
**Chiropractic Medicine**

The Financial Responsibility options are divided into two categories, coverage and exemptions. Choose only ONE option that best describes your situation.

**FINANCIAL RESPONSIBILITY COVERAGE**

\_\_\_\_\_ I have obtained and will maintain professional liability coverage in an amount not less than \$100,000 per claim with a minimum annual aggregate of at least \$300,000 from an authorized insurer as defined under section 624.09, F.S., from an eligible surplus lines insurer as defined under s. 626.914(2), F.S., from the Joint Underwriting Association established under s.627.351(4), F.S., from a risk retention group as defined under s.627.942, F.S., from the Joint Underwriting Association established under s. 627.351(4), F.S., or through a plan of self-insurance as provided in s. 627.357, F.S.

\_\_\_\_\_ I have obtained and will maintain an unexpired, irrevocable letter of credit, established pursuant to Chapter 675, F.S., in an amount not less than \$100,000 per claim, with a minimum aggregate availability of credit of not less than \$300,000. This letter of credit is payable to me as beneficiary upon presentation of a final judgement indicating liability and awarding damages to be paid by me or upon a settlement agreement signed by all parties to such agreement when such final judgement or settlement is a result of a claim arising out of the rendering of , or the failure to render, chiropractic care and services, pursuant to rule 64B2-17.009(2), F.A.C.

**EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:**

\_\_\_\_\_ I practice exclusively as an officer, employee, or agent of the federal government, or of the State of Florida or its agencies or subdivisions.

\_\_\_\_\_ I practice only in conjunction with my teaching duties at an accredited school or in its main teaching hospital.

\_\_\_\_\_ Inactive/not practicing in the State of Florida.

\_\_\_\_\_ Active/not practicing in the State of Florida.

\_\_\_\_\_ I have no malpractice exposure in the State of Florida.

I affirm that these statements are true and correct and recognize that providing false information may result in disciplinary action or criminal penalties as provided in Sections 456.067, 456.072, 755.082 and/or 755.084, Florida Statutes.

\_\_\_\_\_  
Signature of Licensee

\_\_\_\_\_  
Date