

Name: \_\_\_\_\_

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

**PROFESSIONAL LIABILITY COVERAGE AFFIRMATION**

Please select **only one** of the following statements that best describes your liability coverage:

**CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:**

- I hereby certify that I have professional liability coverage in an amount not less than \$10,000 per claim, with a minimum annual aggregate of not less than \$30,000.
- I hereby certify that I have an irrevocable letter of credit, established pursuant to Chapter 675, in an amount not less than \$10,000 per claim, with a minimum aggregate availability of credit no less than \$30,000.
- I hereby certify that I have obtained a surety bond in an amount not less than \$10,000 per claim, with a minimum annual aggregate of not less than \$30,000.

**EXEMPTION CATEGORIES OF FINANCIAL RESPONSIBILITY COVERAGE:**

- I practice exclusively as an officer, employee, or agent of the federal government, or of the state or its agencies or subdivisions.
- I practice only in conjunction with my teaching duties at an accredited acupuncture school.
- I do not practice 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 Section 456.067, 456.072, 755.082 and/or 755.084, Florida Statutes.

\_\_\_\_\_  
Signature (required)

\_\_\_\_\_  
Date