

HAIRSTYLISTS PROFESSIONAL LIABILITY QUESTIONNAIRE

1. Number of Operators: _____ Full Time: _____ Part time (less than 20 hours per week): _____
2. Names and length of experience of all operators. If the space provided is insufficient, please provide a separate list.
- | | | | |
|-------------------|-------|-------|-------|
| 1. Owner/Manager: | _____ | _____ | Years |
| 2. | _____ | _____ | Years |
| 3. | _____ | _____ | Years |
| 4. | _____ | _____ | Years |
| 5. | _____ | _____ | Years |
| 6. | _____ | _____ | Years |
| 7. | _____ | _____ | Years |
3. Are all operators licensed by the provincial / territorial agency having jurisdiction? Yes No
If No, explain (list any operators not licensed):

4. Detail any injuries or alleged injuries arising from the operations of the Owner / Manager or any other operator in the last five years whether or not an insurance claim was made. Add additional page(s) if more space is required.

5. The following services can be covered under our Professional Liability wording. Please advise all applicable:
- | | | | |
|---|--|------------------------------------|--|
| <input type="checkbox"/> Ear Piercing (earlobe only) | <input type="checkbox"/> Manicure / Pedicure | <input type="checkbox"/> Threading | <input type="checkbox"/> Makeup |
| <input type="checkbox"/> Waxing/Sugaring (see #8.) | <input type="checkbox"/> Hair Service | <input type="checkbox"/> Tinting | <input type="checkbox"/> Acrylic Nails |
| <input type="checkbox"/> Gel Nails | | | |
| <input type="checkbox"/> Facials (excluding abrasive, invasive or lymphatic procedures) | Please describe: _____ | | |
6. Please check any other services provided:
- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Body Piercing | <input type="checkbox"/> Botox Injections | <input type="checkbox"/> Toning Beds | <input type="checkbox"/> Suntanning |
| <input type="checkbox"/> Diet / Nutrition | <input type="checkbox"/> Ear Candling | <input type="checkbox"/> Lymphatic Drainage | <input type="checkbox"/> Body Wraps |
| <input type="checkbox"/> Laser Treatments | <input type="checkbox"/> Permanent Makeup | <input type="checkbox"/> Reflexology | <input type="checkbox"/> Collagen Injections |
| <input type="checkbox"/> Electrolysis | <input type="checkbox"/> Aromatherapy | <input type="checkbox"/> Thermolysis | <input type="checkbox"/> Henna Tattoos (<input type="checkbox"/> brown <input type="checkbox"/> black) |
| <input type="checkbox"/> Massage Therapy (specify types) _____ | | | |
| <input type="checkbox"/> Other (describe) _____ | | | |
7. If artificial nail services are provided, is methyl methacrylate (MMA) used *in any form*? Yes No
8. If Body Waxing or Sugaring is done please advise the following:
What type of heating equipment is used: warmer heating pot roller
Age of heating equipment? _____
Does the heating equipment have a temperature control? Yes No
Is the accuracy of the temperature checked before each application? Yes No
If yes, please explain: _____
What type of waxing or sugaring is performed:
 Face/Brow Legs and Arms Underarms Bikini Brazilian Other _____

If available, a copy of the applicant's business brochure must accompany this questionnaire.