PREMIER canada

HEALTH & WELLNESS PROGRAM - FULL SPA OPERATIONS APPLICATION

Brokerage: Phone:

Producer Name: Fax:

Broker Email:

GENERAL INFORMATION

Legal Business Name: _____

Location Address: _____ City: _____ Province: _____ Postal: _____

Mailing (if different): _____ City: _____ Province: _____ Postal: _____

Contact Person: _____ E-mail: _____ Website Address: _____

Phone #: _____ Fax#: _____ Res. #: _____ Cell #: _____

Expiry Date of Policy: _____

Current Insurance Company: _____ **Risk Ever Been Canceled:** ☐YES ☐NO

Target Premium: $ _____ # of years in business: _____ # of years of experience: _____

PLEASE PROVIDE A BROCHURE OF YOUR OPERATIONS WHEN YOU SUBMIT THIS APPLICATION

Does the applicant currently carry Professional Liability insurance? ☐YES ☐NO

If yes, what is the retroactive date on the current Professional Liability policy? _____

Has the company had claims against them in last 5 years? ☐YES ☐NO

If yes, please explain: _____

Has the any staff (including contract staff) had claims against them in last 5 years**?** ☐YES ☐NO

If yes, please explain: _____

PROPERTY INFORMATION

Describe your location (Two storey, strip plaza, shopping mall, etc.) _____ No. of Stories: _____

Do you own the building? ☐YES☐NO Total Area of your Facility: _____ Ft

The Building Age: _____ Latest Update: Roof _____ Heat _____ Plumbing _____ Electric _____

Fire Hydrants within 500 Feet? ☐YES ☐NO Restaurant within 2 adjacent units: ☐YES ☐NO Building Sprinklered? ☐YES ☐NO

Burglar Alarm? ☐Monitored ☐Local ☐NO Fire Alarm? ☐Monitored ☐Local ☐NO

Surveillance System? ☐YES ☐NO # of Fire Extinguishers:

Doors have deadbolts? ☐YES ☐NO Bars on Doors/Windows? ☐YES ☐NO

What is at - Front**:** _____ Back: _____ Left: _____ Right: _____

Construction of Building: _____

Loss Payee Information: (i.e.: bank financing, equipment leases, etc.)

_____

"PROPERTY VALUES" (IF YOU HAD TO REPLACE THE FOLLOWING ITEMS TODAY)

Building (if required) $ _____ Equipment $ _____ Profits / BI $ _____

Leasehold Improvements $ _____ Stock $ _____

Liability Limits Desired: ☐ $1,000,000 ☐ $2,000,000 ☐ $3,000,000 ☐ $4,000,000 ☐ $5,000,000

LIABILITY INFORMATION

Are all inks/pigments from US or Canadian manufacturers? ☐YES ☐NO

Do you dispose of your pigments after each client? ☐YES ☐NO

Do you sell any inks/pigments? ☐YES ☐NO

Do you ever re-use needles? ☐YES ☐NO

Are any clients under the age of 18? ☐YES ☐NO

If yes, please advise minimum age: _____

If yes, please advise what services are provided to these individuals:

_____

NOTE: Please advise if any of the following services are provided.

Physical Therapist on Staff	☐YES ☐NO	Chiropractors on staff	☐YES ☐NO
All Piercings other than Ear / Nose	☐YES ☐NO	Mole Removal – Invasive Cutting	☐YES ☐NO
Tattooing – Permanent Body	☐YES ☐NO	Skin Tag Removal – Invasive Cutting	☐YES ☐NO
Wart Removal – Invasive Cutting	☐YES ☐NO		

DESCRIPTION OF OPERATIONS:

Hairdressing and Beautician Operations: **Estimated Gross Annual Receipts: $ _____**

Barbering / Shaving	☐YES ☐NO	Make up – non permanent	☐YES ☐NO
Facials	☐YES ☐NO	Manicure/pedicures (including nail treatments / extensions and nail art)	☐YES ☐NO
Hair cutting and related service other than hair extension, wig/hair piece fitting/sales	☐YES ☐NO		

Basic Esthetics/ Miscellaneous Professional Services: **Estimated Gross Annual Receipts: $ _____**

Acoustic wave therapy body contouring	☐YES ☐NO	Hypnotherapy other than for past life regression and entertainment	☐YES ☐NO
Acupressure	☐YES ☐NO	Infrared Saunas and massage booths/beds	☐YES ☐NO
Acupuncture other than Moxibustion acupuncture	☐YES ☐NO	Ionization detoxification	☐YES ☐NO
Alkaline skin wash	☐YES ☐NO	Iridology	☐YES ☐NO
Application of local anesthetic topical creams for pain relief during aesthetic treatments	☐YES ☐NO	Kinesiology taping	☐YES ☐NO
Aromatherapy	☐YES ☐NO	Latisse eyelash growth serum	☐YES ☐NO
Aquatic massage beds	☐YES ☐NO	LED Light Therapy	☐YES ☐NO
Art therapy	☐YES ☐NO	Lymphatic massage	☐YES ☐NO
Biofeedback therapy	☐YES ☐NO	Make up (non-permanent)	☐YES ☐NO
BioSkin Jetting / BioSkin smoothing	☐YES ☐NO	Manicures/pedicures	☐YES ☐NO
Blue Light Therapy	☐YES ☐NO	Massage including relaxation massage, registered massage, but does not include services to children under the age of 12 and Myofascial massage	☐YES ☐NO
Brain wave harmony	☐YES ☐NO	Microblading	☐YES ☐NO
Brow Lamination	☐YES ☐NO	Microshading / Ombre Brows	☐YES ☐NO
Cellulite treatment other than cellulite reduction weight loss	☐YES ☐NO	Neuro emotional clearing	☐YES ☐NO
Chemical Acid Peels less than 31% solution concentration	☐YES ☐NO	NLP – Neurolinguistic Programming	☐YES ☐NO
Colon irrigation	☐YES ☐NO	Non-Invasive Laser / Lipolysis Body Contouring and firming procedure	☐YES ☐NO
Dance movement therapy	☐YES ☐NO	Nutritional consulting to follow the Canada Food Guide only	☐YES ☐NO
Dermaplaning	☐YES ☐NO	Oxygen treatments other than hyperbaric chambers	☐YES ☐NO
Dry cupping – excludes wet and fire cupping	☐YES ☐NO	Paraffin	☐YES ☐NO
Ear Candling	☐YES ☐NO	Piercing – ears and nose only	☐YES ☐NO
EFT – Emotional Freedom Technique / Clearing	☐YES ☐NO	Pilates	☐YES ☐NO
Electrolysis hair removal	☐YES ☐NO	Pregnancy massage	☐YES ☐NO
Energy Healing	☐YES ☐NO	Reflexology	☐YES ☐NO
Eyebrow Tinting	☐YES ☐NO	Reiki	☐YES ☐NO
Eyelash Dipping	☐YES ☐NO	Shamanic healing (no contact and no supply of substances)	☐YES ☐NO

Eyelash Extensions	☐YES ☐NO	Skin Booster injections via mesotherapy (microneedling, dermaroller, nappage, and dermapen)	☐YES ☐NO
Eyelash Tinting / perming / lifting	☐YES ☐NO	Sound therapy	☐YES ☐NO
Face / body painting, application of glitter and henna (excluding black henna or Paraphenylenediamine/PPD)	☐ YES ☐NO	Speech and language therapy	☐YES ☐NO
Facial and body wraps / scrubs / masks	☐YES ☐NO	Spray tanning	☐YES ☐NO
Facials	☐YES ☐NO	Spray tattooing	☐YES ☐NO
Glitter Tattooing – non-permanent	☐YES ☐NO	Tanning – UV – sunbeds	☐YES ☐NO
Gua sha	☐YES ☐NO	Threading and tweezing	☐YES ☐NO
Hair stylist including hair extensions, sale of wigs / wig fitting	☐YES ☐NO	Toning beds	☐YES ☐NO
High Intensity Focused Ultrasound (other than vaginal tightening and incontinence treatment)	☐YES ☐NO	Tooth gems	☐YES ☐NO
Holistic Vitamins	☐YES ☐NO	Wart removal by solution only	☐YES ☐NO
Hydration machine	☐YES ☐NO	Waxing, epilation, sugaring, hair bleaching, and application of hair removal cream	☐YES ☐NO
Hydrotherapy salt floatation chambers	☐YES ☐NO	Yoga (Hot yoga excluded)	☐YES ☐NO
Hyperhidrosis treatment via iontophoresis	☐YES ☐NO		

Mid-Range Esthetics **Estimated Gross Annual Receipts: $ _____**

Arasy fat reducing / toning machines	☐YES ☐NO	Microdermabrasion / Hydrodermabrasion	☐YES ☐NO
BB Glow	☐YES ☐NO	Micropigmentation / semi-permanent make-up / Camouflage tattoo	☐YES ☐NO
Body vibration fitness machines	☐YES ☐NO	Mole removal by solution only (excludes cutting and diagnostic)	☐YES ☐NO
Carboxy therapy	☐YES ☐NO	Mole removal via cryopen / freezepen, laser or electrolysis (excludes excision)	☐YES ☐NO
Chemical Acid peels greater than 30% but less than 61% solution concentration	☐YES ☐NO	Myofascial massage	☐YES ☐NO
Cool Sculpting / Cryolipolysis	☐YES ☐NO	Oxygeneo facials and skin tightening	☐YES ☐NO
Electrocoagulation thread vein removal	☐YES ☐NO	Plasma-Pen / Fibroblast	☐YES ☐NO
EMS – Electro Muscular Stimulation including Acuscope and Myopulse / electrotherapy muscle recovery	☐YES ☐NO	Radio frequency treatments	☐YES ☐NO
Emsculpt / Emsella / Emsculpt Neo	☐YES ☐NO	Radiofrequency / Microneedling combined treatment (such as Profound RF or Morpheus 8)	☐YES ☐NO
Endermologie	☐YES ☐NO	Sclerotherapy	☐YES ☐NO
Fluid Isometrics	☐YES ☐NO	Shockwave therapy	☐YES ☐NO
Fractional Skin Resurfacing Radiofrequency treatment (includes Fractora)	☐YES ☐NO	Skin and micro-needling	☐YES ☐NO
Hii Pen, Hya Pen, and Hyaluron Pen	☐YES ☐NO	Skin tag and wart removal by solution, cryopen, Freeze pen, laser or electrolysis (excludes cutting)	☐YES ☐NO
Laser carbon facial	☐YES ☐NO	Teeth whitening	☐YES ☐NO
Laser/IPL/EPL/LHE various operations but not including laser treatments for purposes other than skin and hair treatment	☐YES ☐NO	Thermolysis / Thermo-lo / diathermy – for skin tags/spider vein treatment	☐YES ☐NO
LILT & LLLT – low intensity laser therapy for weight reduction and gain, addictions, mental illness, and pain reduction	☐YES ☐NO	Thread vein removal via laser or electrolysis	☐YES ☐NO
Magnetic pulsed field therapy	☐YES ☐NO	Ultrasonic Cavitation	☐YES ☐NO

Meta therapy	☐YES ☐NO	Ultrasound treatment for hair restoration (including Alma Ted)	☐YES ☐NO
Micro-current facials and body treatment	☐YES ☐NO	Vaginal Tightening and Incontinence Treatment – Any internal treatments must be performed by a Doctor, Registered Nurse or Nurse Practitioner (such as Enfemme 360)	☐YES ☐NO

High End Esthetics: **Estimated Gross Annual Receipts: $** _____

Bio resonance diagnostics	☐YES ☐NO	Local Anesthetic injections for Aesthetic Treatments	☐YES ☐NO
Botulinum Toxin injections (including Platysmal Bands, Masseter, Vshape Definition, Gummy Smile and Hyperhydrosis	☐YES ☐NO	Platelet Rich Fibrin (PRF) for cosmetic purposes (excluding genitalia)	☐YES ☐NO
Cellulite reduction and body contouring and slimming by electronic device	☐YES ☐NO	Platelet Rich Plasma (PRP) for facial and neck rejuvenation	☐YES ☐NO
Hyaluronic Acid Dermal fillers (facial including Lip, Cheek, Jaw, Chin, Breast, Tear Troughs, Non-Surgical Rhinoplasty and Russian Lip) excluding genitalia	☐YES ☐NO	Platelet Rich Plasma (PRP) for purposes of Hair restoration administration of PRP to the genital (including O and P shots) must be performed by a Doctor, Registered Nurse, Nurse Practitioner or Licensed/Registered Practical Nurse	☐YES ☐NO
Hyaluronidase / Hyalase / Hyaluron reversal agent	☐YES ☐NO	Tattoo removal by Eliminink system	☐YES ☐NO
Intramuscular vitamin injections (including vitamin B12)	☐YES ☐NO	Tattoo removal by Laser/IPL/EPL/LHE	☐YES ☐NO
Intra-muscular cortico-steroid injections/creams to treat psoriasis, acne, eczema, onychomycosis and scarring	☐YES ☐NO	Thread lifting (Dissolvable – including PDO/Silhouette Soft/COG/Mono)	☐YES ☐NO
Intravenous vitamin infusion therapy	☐YES ☐NO	Weight loss / fat-dissolving injections (including but not limited to Aqualyx, Lipolax, Desoface, body, Lipolab)	☐YES ☐NO

Teaching Operations: **Estimated Gross Annual Receipts: $** _____

Teaching and students offering service(s) to the public while under supervision ☐YES ☐NO

Product/Retail Sales: **Estimated Gross Annual Receipts: $** _____

☐YES ☐NO If yes, please confirm product/retails are usual to services being provided. ☐YES ☐NO

Do you relabel or repackage any products? ☐YES ☐NO

If yes, please provide type of products sold, relabeled, repackaged: _____

Other Operations: **Estimated Gross Annual Receipts: $** _____

☐YES ☐NO If yes, please describe: _____

WET AREAS # of Swimming Pools? _____

Diving Boards ☐YES ☐NO

Are there any Slides ☐YES ☐NO

Chemicals Tested Daily ☐YES ☐NO

Hot Tub / Whirl Pool / Sauna / Steam Room # of units _____ ☐YES ☐NO

ADDITIONAL INFORMATION

Do you use a deep fat fryer?	☐YES ☐NO	Do you ever serve alcohol as part of your service?	☐YES ☐NO
Snack Bar on Premises?	☐YES ☐NO	Do you rent space to associated businesses?	☐YES ☐NO

If yes, please describe: _____

Do you bring any specialists into your premise to provide additional operations? ☐YES ☐NO

If yes, please describe: _____

Are there any operations or activities away from the premises? ☐YES ☐NO

If yes, please describe: _____

Please confirm if any products used or being sold contain any formaldehyde? ☐YES ☐NO

Please confirm that you are meeting Health Canada standards with respect to sterilization / cross-contamination prevention procedure. ☐YES ☐NO

Are any of the following operations conducted?

Massage - Registered ☐ YES ☐ NO → If yes, please **complete the Massage Supplementary application**

Tanning Beds & Booths ☐ YES ☐ NO → If yes, please **complete the Tanning Supplementary application**

Laser / IPL Treatment ☐ YES ☐ NO → If yes, please **complete the Laser / IPL Supplementary application**

Teaching Operations ☐ YES ☐ NO → If yes, please **complete the Teaching Supplementary application**

Teeth Whitening ☐ YES ☐ NO → If yes, please **complete the Teeth Whitening Supplementary application**

Full Time / Contract Employee Information:

of **Full time (F/T)** Employees? _____ # of **Part time (P/T)** Employees? _____

of **Contract** People? _____

NAME	YEARS OF EDUCATION	YEARS OF EXPERIENCE	OPERATIONS OF EACH INDIVIDUAL	F/T, P/T OR CONTRACT	CERTIFICATION ATTACHED?

- **ADDITIONAL INSURED** (i.e.: landlord) _____

**** CYBER LIABILITY ****

Does the Company store any medical/health information for clients? ☐ YES ☐ NO

▪ If yes, does the Company follow the minimum standards under the HIPAA (encryption and firewalls in place)? ☐ YES ☐ NO

▪ If yes, does the Company follow the minimum standards under PIPEDA or the respective PIPA requirements (encryption and firewalls in place)? ☐ YES ☐ NO

STATEMENT OF FACT

IMPORTANT INFORMATION – this policy will only cover you for specified aesthetic treatments as per the application. It will not cover you for any other clinical activity. Please confirm you are in agreement with the following Statements of Facts and the Declaration. If you are unable to confirm the Declaration, please refer to Premier Canada advising the reason(s) why.

Statement of Facts:

If you, the insured, or any practitioner on your behalf, is performing injectable treatments, please confirm **one or more** of the below statements is true:

All practitioners performing injectables (Botulinum Toxin and dermal filler injections) are a registered medical practitioner (doctor), registered Nurse, practical nurse, Nurse practitioner or a registered dentist

AND hold a current license to practice with the relevant provincial regulatory body (licensing) authority for the province or territory in which they operate

AND Minimum 3 years' experience in injectable treatments

AND Canadian accredited training certificates for the injectable treatments you wish to perform

Please confirm the below statements are **all** true:

You, the Insured, and all practitioners performing treatments on your behalf hold Canadian accredited training certificates treatments you wish to perform (proof may be required in the event of a claim)

AND hold minimum 12 months experience in all treatments for you may be providing training for

AND confirm the treatments and income are correct as per the policy schedule

AND have had continuous Claims Made cover in force from the date which has been selected as the Retroactive Date or do not require cover prior to inception

You, the Insured, and all practitioners performing treatments on your behalf do <u>not provide</u>: any non-aesthetic treatments to professional sports individuals or elite athletes

AND any spinal joint manipulation where a high velocity manipulation consisting of a violent thrust and contortion of the spine is used to achieve the audible popping sounds or cracking of the cervical, lumbar, or thoracic spine in an attempt to realign or adjust the spine

AND any treatments relating to clinical trials

You, the Insured, and all practitioners performing treatments on your behalf have <u>never</u> been: refused, suspended, withdrawn, or had conditions or restrictions imposed, by the relevant regulatory or licensing body for any province or territory

AND subject to a criminal conviction (excluding motor vehicle offences or any convictions considered spent in the province or territory you operate within) or have any pending criminal matters awaiting a court hearing

AND subject to any claim or circumstance or complaint which may result in a Medical Malpractice, Professional Indemnity or Commercial General Liability claim

Declaration

All the statements in this Statement of Facts together with any oral or written statements provided to us are true, complete and not misleading.

You the insured have confirmed: ☐ Yes

This statement does not obligate us to provide insurance cover.

DECLARATION / CONSENT

PLEASE READ BEFORE SIGNING: A claim will become invalid and the Insured's right of recovery is forfeited where (a) an Applicant for this contract gives false particulars to the prejudice of the insurer or knowingly misrepresents or fails to disclose any fact in any part of this application required to be stated therein; or (b) the insured fails to inform material changes to these facts during the term of the contract; (c) the insured contravenes a term of the contract or commits a fraud; or (d) the insured willfully makes a false statement in respect of a claim.

The Applicants have reviewed all parts and attachments of this application and acknowledge that all information is true and correct and understand that this application for insurance is based on the truth and completeness of this information.

The personal information provided in this document and in the future including, but not limited to, credit information and claims history may be collected, used and disclosed by the insured's representative or insurance company, subject to local legislation, for the purpose of communicating with the insured or their representative, assessing the application for insurance and underwriting any such policies, evaluating claims, detecting and preventing fraud, and analyzing business results. I confirm that all individuals whose personal information is contained in this document have authorized that I agree to the above on their behalf.

NOTE: Insurance is not in effect until Premier has issued a binder or policy documents.

Insured Signature:	Date:
Broker Signature:	Date:
Broker Email:	

Premier Canada Assurance Managers Ltd. is one of Canada's largest Managing Underwriting Agents. The underwriting insurance carrier varies by line of business and region - please refer to specific quote for declaration of the underwriting insurance company(s).

**** Email application and attachments to - newbizcommercial@premiergroup.ca ****

Vancouver - T 604.669.5211 F 604.669.2667 **London - T 519.850.1610 F 519.850.1614**

LASER SUPPLEMENTARY APPLICATION

★PLEASE COMPLETE **ALL** QUESTIONS★

★IF YOU REQUIRE ADDITIONAL SPACE, PLEASE ADD ADDITIONAL PAGES AS NECESSARY★

Please advise IF and HOW you provide the following operations (Please check all lines of operations):

SERVICE	LASER		PULSE LIGHT/IPL	
	YES	NO	YES	NO
Acne	☐	☐	☐	☐
Endovenous Laser Treatment	☐	☐	☐	☐
Leg Veins	☐	☐	☐	☐
Psoriasis & Vitiligo	☐	☐	☐	☐
Skin Resurfacing	☐	☐	☐	☐
Cosmetic Re-pigmentation	☐	☐	☐	☐
Hair Removal	☐	☐	☐	☐
Pigmented Lesions	☐	☐	☐	☐
Vascular Lesions	☐	☐	☐	☐
Cellulite Treatment	☐	☐	☐	☐
Moles, Skintags, and Wart Removal	☐	☐	☐	☐
Tattoo Removal	☐	☐	☐	☐
Other (please describe):	☐	☐	☐	☐

****Please provide all operators who provide laser treatment or cellulite treatment and their experience:**

NAME PERSON PROVIDING LASER TREATMENT	YEARS OF EDUCATION	YEARS EXPERIENCE/ QUALIFICATION	ANY PRIOR CLAIMS MADE AGAINST EACH INDIVIDUAL (PLEASE GIVE BRIEF DETAILS)

****Complete this section for all laser/cellulite machines (please list additional hand pieces separately):**

MAKE	MODEL	AGE	CURRENT REPLACEMENT COST IN CANADIAN $$
		Yrs.	$
		Yrs.	$
		Yrs.	$
		Yrs.	$
		Yrs.	$
		Yrs.	$
		Yrs.	$
		Yrs.	$

Please answer all questions:

1. Please circle what skin types you provide services on for the laser treatments:
   As per the Fitzpatrick Scale: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6
2. Do you complete a skin patch test prior to laser treatments? ☐YES ☐NO

Please note that all Laser/IPL/EPL/LHE treatments must comply with Laser/IPL/EPL/LHE Equipment Condition that forms part of the policy.

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3. Do you wear surgical gloves when providing laser services to clients? ☐YES ☐NO
4. Does your client wear protective eyewear during laser services? ☐YES ☐NO
5. Do you keep copies of all client service records? **(**Must be kept on file for min. 7 years)** ☐YES ☐NO
6. Is a waiver signed, dated and kept on record? **(**Must be kept on file for min. 7 years)** ☐YES ☐NO
7. Do you explain to the client what steps to take prior to any laser treatment? ☐YES ☐NO

   Please describe: _____
8. Do you explain to the client what steps to take after any laser treatment? ☐YES ☐NO

   Please describe**:** _____
9. How often do you calibrate your machines? _____
10. Please confirm that all equipment is CSA approved. ☐YES ☐NO
11. Do you provide any off-site laser treatments? ☐YES ☐NO

MASSAGE SUPPLEMENTARY APPLICATION

Please complete this section for all Massage Therapists on Staff:

NAME OF MASSAGE THERAPIST	TYPE(S) OF MASSAGE THEY PERFORM (please list all)	YEARS OF EDUCATION	YEARS OF EXPERIENCE	ARE YOU AN RMT?	
				YES	NO
				☐	☐
				☐	☐
				☐	☐
				☐	☐

1 Do you collect and discuss the client's health information? ☐YES ☐NO

2 Is a waiver signed, dated and kept on record? **(**Must be kept on file for min. 7 years)** ☐YES ☐NO

3 Do you offer massages to infants? ☐YES ☐NO

4 Have any of the masseuses listed above had a claim made against them? ☐YES ☐NO

If so, please advise: _____

TANNING SALON SUPPLEMENTARY APPLICATION

LIABILITY INFORMATION – Limits will be the same as the main operations that you have provided.

EQUIPMENT INFORMATION	Age	# of Units	Type of Timer (digital, coin, token, manual, etc.)
BEDS			
BOOTHS			
SPRAY BOOTHS			
AIR BRUSH			

Who Changes the Bulbs? _____

Do all client sign waivers? ☐YES ☐NO

Are clients given tanning instructions? ☐YES ☐NO

Do any beds operate by tokens/coins? ☐YES ☐NO

Do all clients complete skin analysis? ☐YES ☐NO

Are clients required to wear goggles? ☐YES ☐NO

Are signs posted to wear goggles? ☐YES ☐NO

Does the sign in sheet that clients initial prior to each session state that "Clients Must Wear Eye Goggles"? ☐YES ☐NO

Are the Tanning Staff Smart Tan or Equivalent Certified? ☐YES ☐NO

Is Equipment Inspected and Cleaned After Each Use? ☐YES ☐NO

Who sets the amount of time a client is able to tan on each bed? ☐ CLIENT or ☐ STAFF

Where is the timer located, which sets the amount of time a client tan? ☐ FRONT DESK or ☐ BED

Are tanning sessions and waiver records saved and filed for NO less than 2 years? ☐YES ☐NO

Is the tanning salon listed as a full member of Smart Tan Canada? ☐YES ☐NO

Please check "YES" so that we can confirm this information with Smart Tan Canada ☐YES ☐NO

Do you rent space to others within your unit? ☐YES ☐NO

If yes, do they list you as an additional insured? ☐YES ☐NO

If yes, please advise name of lessee: _____

_____

TEACHING SUPPLEMENTAL APPLICATION

Legal Business Name:

Name Person Instructing Class	Certified to teach	Years providing service	Any prior claims

Is the applicant/insured certifying students? ☐ YES ☐ NO

Can someone without any esthetics experience take a course? ☐ YES ☐ NO

Is there additional training offered to students without prior esthetics? ☐ YES ☐ NO

List all courses offered:

_____

_____

_____

Number of Students per year? _____

Number of hours students complete prior to graduations? _____

Is the final exam proctored by the provincial regulator? ☐ YES ☐ NO

Do students offer services to the public: ☐ YES ☐ NO

If yes, 1. the number of hours completed prior to offering any services to the public: _____

2. Do all clients sign a waiver holding the school and student harmless? ☐ YES ☐ NO
3. Are the students supervised at all times when offering service to the public? ☐ YES ☐ NO
4. Do students offer Micropigmentation services to the public? ☐ YES ☐ NO
5. Do students offer Laser/IPL services to the public? ☐ YES ☐ NO
6. Do students offer Body Injection services to the public? ☐ YES ☐ NO
7. Does the applicant teach Platelet Rich Plasma (PRP) services to the public? ☐ YES ☐ NO
8. Does the applicant teach Plasma Pen services to the public? ☐ YES ☐ NO

ESTIMATED ANNUAL GROSS RECEIPTS:

Public Services by Students $ _____

Public Services by Non Students $ _____

Tuition Fees $ _____

Total Yearly Teaching Receipts Gross Sales & Operation Receipts $ _____

TEETH WHITENING SUPPLEMENTAL APPLICATION

1. Does all staff wear sterilized gloves when performing services? ☐ YES ☐ NO
2. Is the product manufactured in North America? ☐ YES ☐ NO
   If no, where? _____
   Is it approved for use by Health Canada? ☐ YES ☐ NO
3. Do all clients sign a hold harmless agreement or a consent form prior to offering service the first time? ☐ YES ☐ NO
4. Do you manufacture or fit any Teeth whitening appliance for client? ☐ YES ☐ NO
5. Maximum % of Carbomide Solution Used: _____
6. Maximum % of Hydrogen Peroxide Solution Used: _____
7. Please advise length solution is kept on teeth: _____
8. Please advise number of treatments in 1 visit: _____
9. Have you ever had a claim made against you? ☐ YES ☐ NO
   If yes, please advise: _____

Name Brand of teeth whitening product used: _____