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 INFORMATION

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

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

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

Do you ever re-use needles? ☐YES ☐NO

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

Description of Operations:

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

NOTE: we cannot offer coverage for the following services at this time. Please advise if these 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		

Basic Esthetics: **Estimated Gross Annual Receipts: $ _____**

Acid Peels less than 31% solution concentration	☐YES ☐NO	Hydrotherapy salt floatation chambers	☐YES ☐NO
Acupuncture other than Moxibustion acupuncture	☐YES ☐NO	Hypnotherapy other than for past life regression and entertainment	☐YES ☐NO
Acupressure	☐YES ☐NO	Infrared Saunas and massage booths/beds	☐YES ☐NO
Aquatic massage beds	☐YES ☐NO	Ionization detoxification	☐YES ☐NO
Biofeedback therapy	☐YES ☐NO	Iridology	☐ YES ☐NO
Body wraps	☐YES ☐NO	Make up – non permanent	☐YES ☐NO
Brain wave harmony	☐YES ☐NO	Manicure/pedicures	☐YES ☐NO
Cellulite treatment other than cellulite reduction weight loss	☐YES ☐NO	Massage including relaxation massage, registered massage, reiki, reflexology, and aromatherapy, but does not include services to children under the age of 12 and Myofascial massage	☐YES ☐NO
Colon irrigation	☐YES ☐NO	Neuro emotional Clearing	☐YES ☐NO
Dry Cupping – Wet Cupping is excluded	☐YES ☐NO	NLP – Neurolingulistic Programming	
Dermaplanning	☐YES ☐NO	Nutritional consulting to follow the Canada Food Guide only	☐YES ☐NO
Ear candling	☐YES ☐NO	Oxygen treatments other than hyperbaric chambers	☐YES ☐NO
Energy healing	☐YES ☐NO	Piercing – ears and nose only	☐YES ☐NO
Electrolysis	☐YES ☐NO	Shamanic healing	☐YES ☐NO
EFT – Emotional Freedom Technique/Clearing	☐YES ☐NO	Spray tanning	☐YES ☐NO
Eyebrow Tinting	☐YES ☐NO	Spray tattooing	☐YES ☐NO
Facials	☐YES ☐NO	Sugaring	☐YES ☐NO
Glitter Tattooing – non permanent	☐YES ☐NO	Threading	☐YES ☐NO
Hair cutting and related service other than hair extension, wig/hair piece fitting/ sales	☐YES ☐NO	Toning beds	☐YES ☐NO
Henna Tattooing	☐YES ☐NO	Wart removal by solution only	☐YES ☐NO
High Intensity focused ultrasound (other than vaginal tightening and incontinence treatment)	☐YES ☐NO	Waxing	☐YES ☐NO
Hydration machine	☐YES ☐NO		

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

Acid peels greater than 30% but less than 61% solution concentration	☐YES ☐NO	Micropigmentation	☐YES ☐NO
Arasy machines	☐YES ☐NO	Mole removal by solution only	☐YES ☐NO
BB Glow	☐YES ☐NO	Myofascial massage	☐YES ☐NO
Body vibration fitness machines	☐YES ☐NO	Oxygeneo	☐YES ☐NO
Coolsculpting	☐YES ☐NO	Plasma-Pen	☐YES ☐NO
Electrocoagulation	☐YES ☐NO	Radio frequency treatments	☐YES ☐NO
EMS – Elector Muscular Stimulation including Acuscope and Myopulse	☐YES ☐NO	Sclerotherapy	☐YES ☐NO
Endermologie	☐YES ☐NO	Skin and micro needling	☐YES ☐NO
Fluid Isometrics	☐YES ☐NO	Skin tag removal by solution or laser	☐YES ☐NO
Hyaluron Pen	☐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	☐YES ☐NO
LILT & LLLT – low intensity laser therapy for weight reduction and gain, addictions, mental illness and pain reduction	☐YES ☐NO	Thermo-Lo	☐YES ☐NO
Micro current treatment	☐YES ☐NO	Vaginal Tightening and Incontinence Treatment	☐YES ☐NO
Microdermabrasion	☐YES ☐NO	Vibrodermabrasion	☐YES ☐NO

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

Cellulite reduction and body contouring and slimming by electronic device	☐YES ☐NO	Tattoo removal by Eliminik	☐YES ☐NO
Bio resonance diagnostics	☐YES ☐NO	Body injections for cosmetic purposes listed within our "injectable supplemental application"	☐YES ☐NO
Tattoo removal by Laser/IPL/EPL/LHE	☐YES ☐NO	Platelet Rich Plasma	☐YES ☐NO

Miscellaneous Professional Services: **Estimated Gross Annual Receipts: $** _____

Brow Lamination	☐YES ☐NO	Microblading	☐YES ☐NO
Eyelash Dipping	☐YES ☐NO	Tooth gems	☐YES ☐NO
Eyelash Extensions	☐YES ☐NO	Wigs and Extensions – Not attached by adhesive	☐YES ☐NO
Eyelash Tinting	☐YES ☐NO	Latisse	☐YES ☐NO
Hair Extensions	☐YES ☐NO	Hollistic Vitamins	☐YES ☐NO
Tanning – UV	☐YES ☐NO		

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

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

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: _____

Do you provide any permanent hair straightening operations? ☐YES ☐NO

If yes, please provide name of products used: _____

Please confirm if any of these products contain any formaldehyde? ☐YES ☐NO

Please describe your sterilization / cross-contamination prevention procedures:

_____

HEALTH & WELLNESS PROGRAM - FULL SPA OPERATIONS APPLICATION

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**
Injectable Services ☐ YES ☐ NO → If yes, please **complete the Injectable 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**
Platelet-rich Plasma ☐ YES ☐ NO → If yes, please **complete the Platelet-rich Plasma(PRP) Supplementary application**
Plasma Pen ☐ YES ☐ NO → If yes, please **complete the Plasma Pen 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

▪ Higher cyber limits may be available, please contact your underwriter for details.

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**

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? _____

Is there any massage offered ☐YES ☐NO Are clients given tanning instructions? ☐YES ☐NO

Do all client sign waivers? ☐YES ☐NO Do all clients complete skin analysis? ☐YES ☐NO

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

So the insured does not have to send us a copy of all Smart Tan certifications and a copy of their membership ---

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

(Premium advantages if each salon location is listed as a Smart Tan Member – Ask us if salons are not members)

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: _____

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	☐	☐	☐	☐
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
3. How long do you wait after the patch test to perform laser treatment? _____
4. Do you wear surgical gloves when providing laser services to clients? ☐YES ☐NO
5. Does your client wear protective eyewear during laser services? ☐YES ☐NO
6. Do you keep copies of all client service records? **(**Must be kept on file for min. 7 years)** ☐YES ☐NO
7. Is a waiver signed, dated and kept on record? (please attach a copy) ☐YES ☐NO
8. Do you explain to the client what steps to take prior to any laser treatment? ☐YES ☐NO
   Please describe: _____
9. Do you explain to the client what steps to take after any laser treatment? ☐YES ☐NO
   Please describe**:** _____
10. How often do you calibrate your machines? _____
11. Do you provide any off-site laser treatments? ☐YES ☐NO
    If yes, list all locations, methods of transporting equipment and frequency of all off-site treatments:
    _____

INJECTABLE SUPPLEMENTAL APPLICATION

Please Complete this section for ALL people performing Injectable services:

RPN = REGISTED PRACTICAL NURSE **RN** = REGISTERD NURSE **NP** = NURSE PRACTITIONER **D** = DOCTOR

NAME	YEARS OF EDUCATION	YEARS OF EXPERIENCE	DO THEY HAVE OWN INSURANCE FOR THIS SERVICE	PROVIDE DESIGNATION AS ABOVE	ADVISE FT, PT, OR CONTRACT

PLEASE CHECK APPLICABLE SERVICES & ADVISE WHO PERFORMS SERVICE (RPN, RN, NP, D – AS NOTED ABOVE)
***** Means this injection must be performed by Doctor**

☐ Aquamid***		☐ Belkyra Deoxycholic		☐ Belotero Balance***	
☐ Bio-Alcamid***		☐ Bioinblue		☐ Botox – Vistabel	
☐ Botox/Dysport/Xeomin/ Azzalure/Neurobloc Bocouture		☐ Dermadeep***		☐ Dermalive	
☐ Elastence		☐ Emervel Lips/Volume Classic		☐ Esthelis Basic/Soft/Glycerol	
☐ Evolence		☐ Evolution***		☐ Hydra-Fill 1/2/3/Softline/Softline Max	
☐ Hylaform / Fineline / Plus		☐ IAL-System		☐ Juvederm Ultra (24)	
☐ Juvederm Ultra XC		☐ Juvederm Ultra Plus (30)		☐ Juvederm Ultra Plus XC	
☐ Juvederm Refine		☐ Juvederm Volift/Volbella		☐ Juvederm Vollure XC	
☐ Laresse		☐ Matridex***		☐ Matridur	
☐ Nuceiva		☐ Outline		☐ Phiderma SR	
☐ Princess Volume / Princess Fillers		☐ Puragen / Puragen Plus		☐ Radiesse	
☐ Ravenesse		☐ Ravenesse Ultra		☐ Redexis	
☐ Redexis Ultra***		☐ Restylane/Touch/Perlane/Lipp (Restylane Lidocaine/Vital)		☐ Restylane Lip Volume / Refresh	
☐ Restylane SubQ / Restylane Lyft / Restylane Kysse / Restylane Refyne / Restylane Defyne / Restylane Volyme / Restylane Skin Boosters		☐ Reviderm Intra***		☐ Sculptra (Poly I Lactic Acid)	
☐ Stylage(S/M/L/XL/Special Lips/Hydromax)		☐ Surgiderm 18/24XP/30/30XP/Surgilips		☐ Surgilift Plus	
☐ Teosyal Global Action/Touch Up/First Lines/Deep Lines/Kiss/Ultra Deep/Pure Sense/Redensity		☐ Teosyal Voluma		☐ Teoyal Pure Sense Ultimate	
☐ Voluma		☐ Viscontour		☐ Zyderm 1/2/Zyplast	
☐ Mesotherapy		☐ Platelet Rich Plasma *Please have PRP Supplemental Application completed*			

List any other injections offered that are not noted above: _____

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

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

If yes to either of the above questions, please list full details on the cover page.

TEACHING SUPPLEMENTAL APPLICATION

Legal Business Name:

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

HEALTH & WELLNESS PROGRAM - FULL SPA OPERATIONS APPLICATION

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: _____

PLATELET-RICH PLASMA(PRP) SUPPLEMENTAL APPLICATION

1. Receipts from Applicant's operations:

Last 12 months (expiring)	Next 12 months (expiring)

2. What PRP services are offered? Check all that apply:

☐ Hair Restoration	☐ Vampire Facials with Skin & Micro needling – excludes facelifts
☐ Vaginal Rejuvenation – O Shots	☐ Neck Rejuvenation
☐ Cellulite **Reduction**	☐ Erectile Dysfunction – P Shots

☐ PRP with Body Injections (i.e. Dermal Filler) ***** Injectable supplement application required***	☐ Teaching / certifying others in PRP ***** Teaching application required***
☐ Other PRP Services, please list: _____	

3. Please provide list of names of ALL employees & sub-contractors who perform PRP services:

NAME PERSON PROVIDING PRP TREATMENT	PRP SERVICES PERFORMED	YEARS OF EXPERIENCE / EDUCATION FOR PRP	ATTACH / LIST ALL CERTIFICATIONS / QUALIFICATIONS	IS THIS PERSON: RN = REGISTED NURSE NP = NURSE PRACTITIONER RPN = REGISTERD PRACTICAL NURSE D = DOCTOR O = OTHER (PLEASE LIST)

Claims History:

4. Has the company had claims against them in the last 5 years? Y ☐ N ☐

5. Has any staff (including contract staff) had claims against them in the last 5 years? Y ☐ N ☐

If yes to either of the above questions, please list full details.

Full Claims Information: _____

_____

_____

PLASMA PEN SUPPLEMENTAL APPLICATION

1. What Plasma Pen services are offered? Check all that apply:

☐ Skin Tightening	☐ Tattoo Removal/lightening *****Unable to Offer Coverage***
☐ Skin tag removal	☐ Mole removal – sign off by a doctor required
☐ Cellulite Reduction	☐ Teaching/certifying others in Plasma Pen (min. 1 year of plasma pen experience) *****Teaching application required***
☐ Other (please list all other services offered): _____	

2. What skin types for you provide services on for Plasma Pen Operations? (Check all that apply)

As per the Fitzpatrick Scale: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5** ☐ 6**

*****Unable to Offer Coverage if services are provided to skin types 5&6***

3. Are waivers and service records signed, dated and kept on file for at least 7 years? ☐ YES ☐ NO

4. Do you provide after care instructions? (Please provide a copy) ☐ YES ☐ NO

5. Please provide the following information regarding the plasma pen/machine used:

MAKE	MODEL	COUNTRY OF ORIGIN	SERVICES PERFORMED	FDA/HEALTH CANADA APPROVED?

6. Please provide the names of ALL employees & sub-contractors who perform Plasma Pen Services

NAME PERSON PROVIDING PLASMA PEN TREATMENT	PLASMA PEN SERVICES PERFORMED	YEARS EXPERIENCE/ EDUCATION FOR PLAMA PEN	YEARS OF BEAUTICIAN RELATED EXPERIENCE	IS THIS PERSON: RN = REGISTERED NURSE NP = NURSE PRACTITIONER RPN = REGISTERED PRACTICAL NURSE D = DOCTOR O = OTHER (PLEASE LIST)

Claims History:

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

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

If yes to either of the above questions, please list full details on the cover page.