STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0042

Family Planning

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:
Connecticut Public Health Code, Section 19-13-D54 and 19a-116-1:

Planned Parenthood of Southern New England of Stamford, CT d/b/a Planned Parenthood of Southern New England is hereby licensed to maintain and operate a Family Planning.

Planned Parenthood of Southern New England is located at 35 Sixth Street, Stamford CT 06905-4603

This license expires **September 30, 2019** and may be revoked for cause at any time.

Dated at Hartford Connecticut, December 21, 2015. **INITIAL**

Raul Pino, MD, MPH
Commissioner

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Facility Licensing and Investigations Section

LP-173

Rev. 7/06

TO: Office of Health Care Access
Dept. of Social Services
Office of Policy Management
Office of Fiscal Analysis
PLIS - Nurse Aide Training
SNC Certification-FLIS
SNC Licensure - FLIS
Consultation Section - FLIS
Building & Fire Safety - FLIS
Facility File

FROM: Christine Jennings, Processing Technician
Facilities Licensing & Investigations Section

DATE: March 30, 2016

Subject: Facility Name Change

Please adjust your records accordingly.

[ ] Chronic & Conv. Nursing Home
[ ] Rest Home with Nsg. Supervision
[ ] Residential Care Home
[X] Outpatient Clinic (family Planning)
[ ] Ambulatory Surgical Center
[ ] Assisted Living Services Agency
[ ] Home Health Care Agency
[ ] Other ___________________
[ ] General Hospital
[ ] Psychiatric Hospital
[ ] Chronic Disease Hospital
[ ] Substance Abuse Facility
[ ] Mental Health Facility
[ ] Outpatient Dialysis Unit
[ ] Well Child Clinic
Type:________________.

Planned Parenthood of Southern New England, Inc. located at 35 Sixth Street Stamford, CT 06906 has:

[X] Opened effective December 21, 2015 with none licensed beds.
[ ] Closed effective ______________ with ________ licensed beds.
[ ] Increased licensed beds from ________ to ________, effective ______________.
[ ] Decreased licensed beds from ________ to ________, effective ______________.
[ ] Relocated to, ______________________ effective ______________.
[ ] Changed d/b/a name to ______________________ effective ______________.
[ ] Changed ownership of the following, effective ______________________.
[ ] Operating entity. New License # is 0042 ______________.
New licensee is ______________________.
[ ] Real property.
[ ] Stock change within the entity that operates the facility.
[ ] Other:.______________________________________.

Type of Ownership:

[ ] Proprietorship
[ ] Limited Partnership
[ ] Profit corporation
[ ] LLC
[x] Non-profit corporation
[ ] Municipality
[ ] Trust

LP-173
Rev. 7/06

Phone: (860) 509-7444
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HFL
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

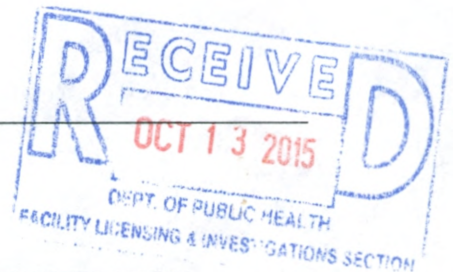
FACILITY LICENSE & INVESTIGATIONS SECTION

LICENSURE APPLICATION

[ ] INITIAL [ ] RENEWAL [ ] CHANGE OF OWNERSHIP [X] RELOCATION

NOTICE: Any nursing home licensee, owner or officer, including, but not limited to, a director, trustee, limited partner, managing partner, general partner or any person having at least 10 per cent (10%) ownership interest, and any administrator, assistant administrator, medical director, director of nursing or assistant director of nursing, may be subject to criminal liability, in addition to civil and administrative sanctions under federal and state law, for the abuse or neglect of a resident of the nursing home perpetrated by an employee of the nursing home.

NOTE: A separate application must be completed for each licensed level of care, whether or not, that level is located at the same address



1. Planned Parenthood of Southern New England_
2. ____________________
Facility "d/b/a" (doing business as) Name

___35 Sixth St Stamford, CT 06905

Business Address City State Zip Code Telephone

____Same____________________
Mailing Address (if applicable) City State Zip Code

2. ___060263565______________________
Federal Employer Identification Number

3. Is the above named entity authorized by the Office of the Secretary of State to transact business in the State of Connecticut and considered in Good Standing? [ ] YES [ ] NO

Phone: (860) 509-7444
Telephone Device for the Deaf (860) 509-719
410 Capitol Avenue - MS # 12HFL
P.O. Box 340308 Hartford, CT 06134

An Equal Opportunity Employer

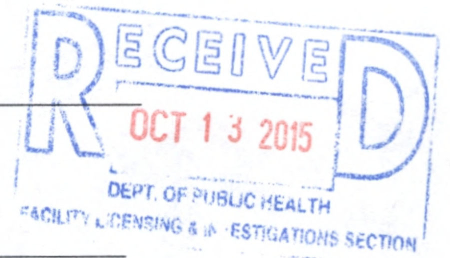
In accordance with Section 19a-491 and/or Section 19a-506 of the Connecticut General Statutes, application is hereby made for a license to operate the following (please check the appropriate box that applies):

[ ] Assisted Living Services Agency
[ ] Children's Hospital
[ ] Chronic and Convalescent Nursing Home
[ ] Chronic Disease Hospital
[X] Family Planning Clinic
[ ] General Hospital
[ ] Home Health Care Agency
[ ] Homemaker-Home Health Aide Agency
[ ] Hospice/19a-495-5a & 19-13-D1(C)
[ ] Hospital for Mentally Ill Persons
[ ] Infirmary Operated by an Educational Institution
[ ] Maternity Home
[ ] Maternity Hospital
[ ] Outpatient Clinic/Primary Care/Dental
[ ] Outpatient Dialysis Unit
[ ] Outpatient Surgical Facility
[ ] Residential Care Home
[ ] Rest Home with Nursing Supervision
[ ] In-Patient Hospice Unit
[ ] Well Child Clinic

4. Bed Capacity Requested (if applicable). If submitting this application for multiple levels of care, please list the bed capacity for each level of care being requested.

Level of Care	Beds/ Hemodialysis Stations	Bassinets (if applicable)
N/A		

5. Disclose the **legal entity which owns/operates the facility**. (Note: The license will be issued to this entity.)



___Planned Parenthood of Southern New England
Licensee

____345 Whitney Avenue New Haven, CT 06511 203.865.5158
Business Address City State Zip Code Telephone

_______Same
Mailing Address (if applicable)

6. Is the above named legal entity a (please check the box which applies):

[ ] Individual/Sole proprietor
[ ] General Partnership
[ ] Limited Partnership
[ ] Limited Liability Company
[ ] Other: ______
[X] Non-profit Corporation
[ ] Municipality
[ ] Trust
[ ] Profit Corporation

7. Please disclose the name, business address and telephone number of the Agent for Service for the Licensee.

_____Judy Tabar 345 Whitney Avenue New Haven, CT 06511 203.865.5158

Name Address Telephone

8. Attach an organizational chart which reflects the current ownership structure of the licensee and the licensee's relationship with the facility/agency.

9. Respond to the specific question that reflects the ownership structure of the licensee. **The Licensee is the legal entity which will be issued the license to operate.**

A. If the Licensee is a **general partnership, limited partnership or limited liability company,** complete Form 1 (attached).

B. If the Licensee is a **trust,** complete Form 2 (attached) for the Licensee.

i. Attach a list including the name, address and telephone number of all trustees.

C. If the Licensee is a **corporation (profit or non-profit)**, complete Form 3 (attached) for the Licensee. Complete a separate Form 3 for each additional corporate entity having 10% or greater ownership interest in the Licensee.

i. If the corporation is incorporated in a state other than Connecticut, please attach a Certificate of Good Standing from the Secretary of State of the state of incorporation.

ii. Attach a list including the name, address and telephone number of all officers and all directors of the corporation.

10. Attach a current copy of the facility's Certificate of malpractice and public liability insurance. (Note: Information Pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.). Please note that All Behavioral Health levels of care, except hospitals, and RCH facilities are exempt from the malpractice requirement.

11. Attach evidence of current compliance with the worker's compensation insurance coverage requirements in the form of one of the following:

A. a certificate of self-insurance issued by a worker's compensation commissioner pursuant to Section 31-284 of the Conn. General Statutes; or

B. a certificate of compliance issued by the Insurance Commissioner pursuant to Section 31-286 of the Conn. General Statutes; or

C. a Certificate of Insurance issued by any stock or mutual insurance company or mutual association authorized to write worker's compensation insurance in this state. (Note: Information pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.)

12. Ownership of Real Property

____Planned Parenthood of Southern New England

Name

_______345 Whitney Avenue New Haven, CT 06511 023.865.5158

Business Address City State Zip Code Telephone

ORGANIZATION CHART

Planned Parenthood of Southern New England, Inc.

BOARD OF DIRECTORS

^

Planned Parenthood of Southern New England Inc.

^

Planned Parenthood of Southern New England Inc.

Planned Parenthood of Southern New England
d/b/a Planned Parenthood of Southern New England

Organizational Chart

Board of Directors 2014-2015

Officers:
Simone Joyaux, Chair
Gayle Capozzalo, Vice Chair
Karen Dubois Walton, Secretary
Leigh Bonney, Treasurer
Fahd Vahidy, Assistant Treasurer

Board of Directors:
Natalie Adsuar. M.D.
Adriana Arreola-Joseph
Bridget Baird
Erica Buchsbaum
Chris Corcoran
Holland Dunn
Siw de Gysser
Susann Mark
Donna Moffly
John R. Morton, M.D.
Francis Padilla
Amelia Renkert-Thomas
Susan Ross

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

Attachment 3

FORM 3

FACILITY/AGENCY NAME: _____Planned Parenthood of Southern New England
____

Form 3 must be completed if the facility/agency or Real Property Owner is owned/operated by a corporation (profit or non-profit). Please copy additional sheets if necessary.

For each stockholder with a 10% or greater ownership interest in the Licensee, provide the information requested below. If no owner owns 10% or more of the total shares, please indicate the two largest stockholders. **Please complete a separate form for each legal entity listed below that is not an individual.**

This information is for: X☐ Licensee __Planned Parenthood of Southern New England
____
☐ Real Property Owner ________________________

1. Name: ____________________
   Address: ____________________
   Telephone: ____________________
   Stockholder's percentage of ownership: ____________________
   Stockholder's occupation with the owner: ____________________

2. Name: ____________________
   Address: ____________________
   Telephone: ____________________
   Stockholder's percentage of ownership: ____________________
   Stockholder's occupation with the owner: ____________________

3. Name: ____________________
   Address: ____________________
   Telephone: ____________________
   Stockholder's percentage of ownership: ____________________
   Stockholder's occupation with the owner: ____________________

4. Name: ____________________
   Address: ____________________
   Telephone: ____________________
   Stockholder's percentage of ownership: ____________________
   Stockholder's occupation with the owner: ____________________

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 01/15/2015

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Marsh USA, Inc.
1166 Avenue of the Americas
New York, NY 10036
Attn: healthcare.accountscss@marsh.com Fax: 212-948-1307

109210-WC-5-5-15-16 NEW,C WC

CONTACT NAME:
PHONE (A/C, No, Ext): FAX (A/C, No):
E-MAIL ADDRESS:

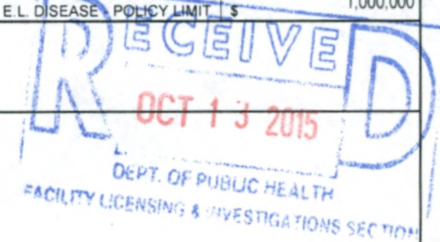
INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : N/A	N/A
INSURER B : ACE American Insurance Company	22667
INSURER C : N/A	N/A
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC., AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.
345 WHITNEY AVENUE
NEW HAVEN, CT 06511

COVERAGES **CERTIFICATE NUMBER:** NYC-006791908-03 **REVISION NUMBER:** 6

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY COMMERCIAL GENERAL LIABILITY CLAIMS-MADE / OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY / PRO-JECT / LOC						EACH OCCURRENCE	$
							DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
							GENERAL AGGREGATE	$
							PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY ANY AUTO ALL OWNED AUTOS / SCHEDULED AUTOS HIRED AUTOS / NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident)	$
							BODILY INJURY (Per person)	$
							BODILY INJURY (Per accident)	$
							PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR EXCESS LIAB / CLAIMS-MADE DED / RETENTION $						EACH OCCURRENCE	$
							AGGREGATE	$
								$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A		RSC C48128865	01/01/2015	01/01/2016	X WC STATU-TORY LIMITS / OTH-ER	
							E.L. EACH ACCIDENT	$ 1,000,000
							E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000



DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
EVIDENCE OF COVERAGE.

CERTIFICATE HOLDER

PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC.
345 WHITNEY AVENUE
NEW HAVEN, CT 06511

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Ricki Fitzsimmons

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 12/31/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
Marsh USA, Inc.
1166 Avenue of the Americas
New York, NY 10036
Attn: healthcare.accountscss@marsh.com Fax: 212-948-1307

109210-NIP-CAS-15-16 NEW,C GLPL

CONTACT NAME:
PHONE (A/C, No, Ext): FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : New Hampshire Insurance Company	23841
INSURER B : National Union Fire Ins. Co. of Pittsburgh, PA	19445
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

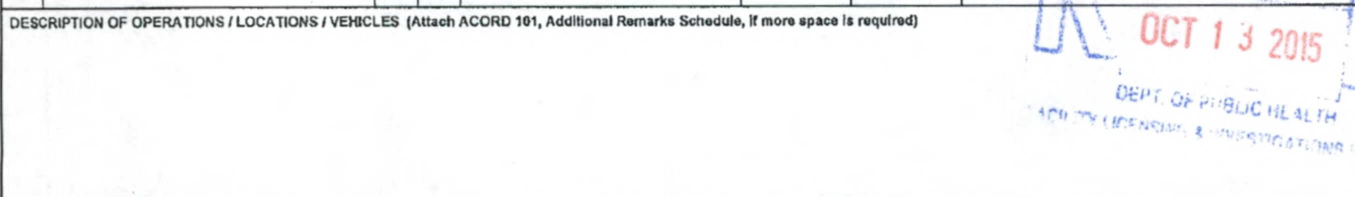
INSURED
PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC.
AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.
345 WHITNEY AVENUE
NEW HAVEN, CT 06511

COVERAGES CERTIFICATE NUMBER: NYC-005757681-27 REVISION NUMBER: 11

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			082695195	01/01/2015	01/01/2016	EACH OCCURRENCE	$ 1,000,000
	X COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
	CLAIMS-MADE X OCCUR						MED EXP (Any one person)	$
	X SIR: $100,000						PERSONAL & ADV INJURY	$ 1,000,000
							GENERAL AGGREGATE	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$ 2,000,000
	POLICY PRO-JECT X LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB / OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB / CLAIMS-MADE						AGGREGATE	$
	DED / RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						WC STATU-TORY LIMITS / OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	N/A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
B	MEDICAL PROFESSIONAL			6793286	01/01/2015	01/01/2016	PER CLAIM	$1,000,000
	CLAIMS-MADE COVERAGE			Program Retro Date: 11/1/76			AGGREGATE	$3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)



CERTIFICATE HOLDER

PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND
ATTN: LOUIS DENEGRE
345 WHITNEY AVENUE
NEW HAVEN, CT 06511

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Ricki Fitzsimmons

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STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

LICENSURE APPLICATION - ADDITIONAL INFORMATION REQUIRED

OUTPATIENT CLINICS, WELL CHILD CLINICS AND FAMILY PLANNING CLINICS

Please respond to all of the following questions:

1. ___________Planned Parenthood of Southern New England
2. ____

Facility "d/b/a" (doing business as) Name
___________35 Sixth St Stamford, CT 06905 203.975.4538
____
Business Address City State Zip Code Telephone

2. Check the appropriate box/boxes describing the services to be provided by the clinic:

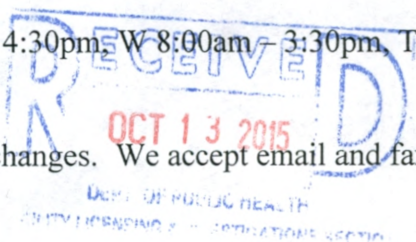
[ ] Primary Care [X] Family Planning
[ ] Well Child Clinic [X] Abortion Procedures
[ ] Dental [ ] Mental Health Services

Be advised that mental health services does NOT include Substance Abuse Services.

3. _____Doris Walden_____________________________________
Administrator (Your name needs to appear as it is shown on your Professional License).

4. ___Timothy Spurrell, MD____ ________________________________
Medical Director Dental Director (if applicable)
(Your name needs to appear as it is shown on your Professional License).

5. Days & Hours of Operation: _M 11:00am – 6:30pm, T 9:00am – 4:30pm, W 8:00am – 3:30pm, TH 9:00am – 4:30pm, F 8:00am – 3:30pm
____



You MUST notify this agency when ANY change to the noted day/time changes. We accept email and fax.

6 Please provide a list of services that will be provided.

7. Business Fax Number: ___(203) 975-4539_____________________________

8. Business Email Address: ___doris.walden@ppsne.org_____________________________

9. Business Cell Phone Number with Texting capabilities of the Administrator:
_203.530.9241_____________.

______________________ 10/1/15 ______________
Signature of Administrator Date Signed

FLIS LICAPP –001
Rev. 3/2015

FOR OFFICE USE ONLY

CHECK # ____________ AMOUNT $______________

DATE RECEIVED ____________ INITIALS ______________

****

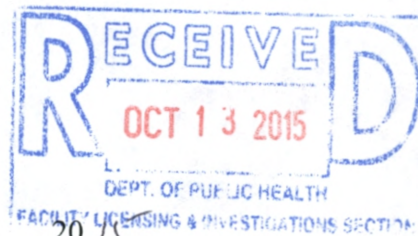
13. Annual Fire Marshal's Certificate of Inspection Form (attached) must be completed by the Local Fire Marshal. **NOTE: Hospitals must have a separate Fire Marshal's Certificate of Inspection completed for each building on the hospital's campus and each satellite listed on the hospital's license. Additional forms may be copied if necessary. Each completed Fire Marshal's Certificate of Inspection that is submitted must have an original signature. (Not applicable for Homemaker Home Health and Home Health Agencies).**

14. Affidavit of Owner:
I attest that the information provided within this application is true and accurate and that any changes in the information submitted will be reported to the Department as required by law.

Judy Tabar 9/30/15
Signature Date Signed

Check one as applicable:

[ ] Individual/Sole Proprietor
[ ] General/Managing Partner
[X] President of Corporation
[ ] Secretary of Corporation
[ ] Municipal Officer
[ ] Trustee
[ ] Member of the LLC



State of Connecticut)

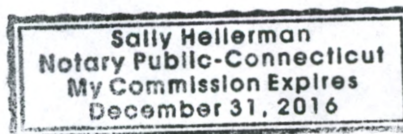
County of New Haven) ss 9/30 20 15

Personally appeared before me the above named Judy Tabar and made oath to the truth of the statements contained in his/her answers to the foregoing questions.

Sally A Heller

Notary Public [✓]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [ ]

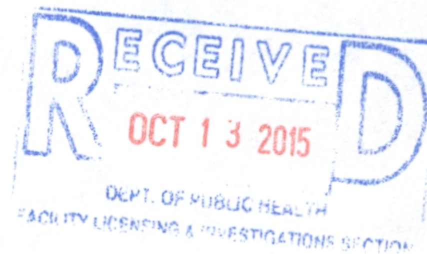
My Commission Expires:
(If Notary Public)



Planned Parenthood of Southern New England

Services available:

- Well women's health care
- Well men's health care
- Cervical cancer screening
- Breast exams
- Sexually transmitted infection testing and treatment
- HIV testing
- Birth control services
- Pregnancy testing
- Options counseling
- Abortion services
- Pre-conception care
- Health and sexual health education services
- Hepatitis and HPV vaccines
- Transgender services



9/28/15

Planned Parenthood®
Care. No matter what.

345 Whitney Avenue
New Haven, CT 06511
p: 203.865.5158 · f: 203.907.2001
ppsne.org

Planned Parenthood of Southern New England

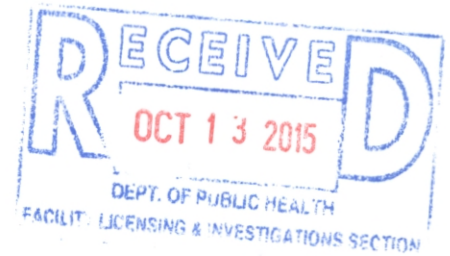
October 6, 2015

Rose McLellan
License & Application Supervisor
State of Connecticut
Department of Public Health
410 Capitiol Avenue MS#12HSR
PO Box 340308
Hartford Connecticut 06134

Dear Rose,

Please enclosed a completed application for the Stamford Center. We plan to relocate the center on November 16, 2015. I also submitted an electronic copy to you today.

Please do not hesitate to contact me if you have questions or are in need of additional documents.



Best regards,

Mary Bawza

COO

Enc.

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

LICENSING INSPECTION REPORT

D/B/A Name and Address of Entity
Planned Parenthood of Stamford
35 Sixth St.
Stamford, CT 06902

Signature of Survey Staff
[signature] RNC

Licensure Category: ______

Licensed Bed/Bassinet Capacity: ______

Census: ______

Date(s) of onsite inspection: 12/15/15

Date(s) additional information obtained: ______

Personnel contacted: Linda Cole - CFO, Sally Hellerman: Dir. Med. Services

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[X] Licensing Inspection [X] *Initial* [ ] *Renewal* [ ] *Other*: (e.g. Strike) ______

[ ] Visit **OR** Revisit for the purpose of ______

[ ] See Complaint Investigation # ______

[ ] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies **were** identified at the time of this inspection. See attached violation letter dated ______

[ ] Desk Audit ______ [ ] Amended Letter date: ______

[ ] Citation # ______ was issued to this facility as a result of this inspection.

[ ] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # ______ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] See Certification File.

[ ] Referred to: ______.

REPORT SUBMITTED BY: [signature] RNC **DATE OF REPORT:** 12/22/15

[X] Approval for issuance of license granted by: [signature] **DATE:** 12/22/15
Supervisor/Title

s:flis\hsr\2009strike\licensure inspection report
Revised 9/2015

Outpatient Clinics

(including Family Planning and Abortion Clinics)

Section	Met	Not met	N/a
Section 19-13-D46			
(a)	☒ met	☐ not met	☐ n/a
(b)	☒ met	☐ not met	☐ n/a
(c)	☒ met	☐ not met	☐ n/a
(d)	☒ met	☐ not met	☐ n/a
Section 19-13-D47	☒ met	☐ not met	☐ n/a
(a)	☒ met	☐ not met	☐ n/a
(a)(1)	☒ met	☐ not met	☐ n/a
(a)(2)	☒ met	☐ not met	☐ n/a
(a)(3)	☒ met	☐ not met	☐ n/a
(b)	☒ met	☐ not met	☐ n/a
(c)	☒ met	☐ not met	☐ n/a
Section 19-13-D48			
(a)	☒ met	☐ not met	☐ n/a
(b)	☒ met	☐ not met	☐ n/a
(b)(1)	☒ met	☐ not met	☐ n/a
(b)(2)	☒ met	☐ not met	☐ n/a
(b)(3)	☒ met	☐ not met	☐ n/a
(b)(4)	☒ met	☐ not met	☐ n/a
(b)(5)	☒ met	☐ not met	☐ n/a
Section 19-13-D49			
(a)	☒ met	☐ not met	☐ n/a
(b)	☒ met	☐ not met	☐ n/a
(c)	☒ met	☐ not met	☐ n/a
Section 19-13-D50	☒ met	☐ not met	☐ n/a
Section 19-13-D51			
(1)	☒ met	☐ not met	☐ n/a
(2)	☒ met	☐ not met	☐ n/a
(3)	☒ met	☐ not met	☐ n/a
(4)	☒ met	☐ not met	☐ n/a
Section 19-13-D52	☒ met	☐ not met	☐ n/a

Outpatient Clinics
(including Family Planning and Abortion Clinics)

Section 19-13-D54 **(Abortion Clinics Only)**

	met	not met	n/a
(a)	[X] met	[ ] not met	[ ] n/a
(b)	[X] met	[ ] not met	[ ] n/a
(c)	[X] met	[ ] not met	[ ] n/a
(d)	[X] met	[ ] not met	[ ] n/a
(d)(1)	[X] met	[ ] not met	[ ] n/a
(d)(2)	[X] met	[ ] not met	[ ] n/a
(d)(3)	[X] met	[ ] not met	[ ] n/a
(d)(4)	[X] met	[ ] not met	[ ] n/a
(d)(5)	[X] met	[ ] not met	[ ] n/a
(d)(6)	[X] met	[ ] not met	[ ] n/a
(d)(7)	[X] met	[ ] not met	[ ] n/a
(d)(8)	[X] met	[ ] not met	[ ] n/a
(d)(9)	[X] met	[ ] not met	[ ] n/a
(d)(10)	[X] met	[ ] not met	[ ] n/a
(d)(11)	[X] met	[ ] not met	[ ] n/a
(e)	[X] met	[ ] not met	[ ] n/a
(f)	[X] met	[ ] not met	[ ] n/a
(g)	[X] met	[ ] not met	[ ] n/a
(h)	[X] met	[ ] not met	[ ] n/a
(i)	[X] met	[ ] not met	[ ] n/a

CITY OF STAMFORD, CONNECTICUT

Building Electrical Mechanical Permits

This is to certify that the Commercial

Located at 35 SIXTH STREET

Building Permit: **B-15-392**

Occupancy ID: **OPP-15-392**

IS HEREBY GRANTED A CERTIFICATE OF APPROVAL

Owner: PLANNED PARENTHOOD OF SOUTHERN N E INC

interior/exterior alterations

Reduce to Core ONLY
to start.

*****REVISED 7/29/15****

Inlcude FULL Tenant Fit-Out

This certificate is granted in conformity with the Statues and Ordinances relating thereto and Expires .... Unless sooner suspended or revoked.

Issued on: **12/21/2015**

Robert D. Demarco