

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0034

Outpatient Clinic

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

Planned Parenthood of Southern New England of New Haven d/b/a Planned Parenthood of
Southern New England Inc. is hereby licensed to maintain and operate a Family Planning
Clinic.

Planned Parenthood of Southern New England Inc. is located at 1229 Albany Avenue,
Hartford, CT 06112.

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

Dated at Hartford Connecticut July 1, 2015. **RENEWAL**



Raul Pino, MD, MPH
Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0034

Outpatient Clinic

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

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

Planned Parenthood Of Southern New England, Inc. is located at 1229 Albany Avenue, Hartford, CT 06112.

This license expires **June 30, 2015** and may be revoked for cause at any time.
Dated at Hartford, Connecticut, July 1, 2011.



Jewel Mullen MD

Jewel Mullen, MD, MPH, MPA
Commissioner

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):

- | | |
|--|---|
| <input type="checkbox"/> Assisted Living Services Agency | <input type="checkbox"/> Infirmary Operated by an Educational Institution |
| <input type="checkbox"/> Children's Hospital | <input type="checkbox"/> Maternity Home |
| <input type="checkbox"/> Chronic and Convalescent Nursing Home | <input type="checkbox"/> Maternity Hospital |
| <input type="checkbox"/> Chronic Disease Hospital | <input type="checkbox"/> Outpatient Clinic/Primary Care/Dental |
| <input checked="" type="checkbox"/> Family Planning Clinic | <input type="checkbox"/> Outpatient Dialysis Unit |
| <input type="checkbox"/> General Hospital | <input type="checkbox"/> Outpatient Surgical Facility |
| <input type="checkbox"/> Home Health Care Agency | <input type="checkbox"/> Residential Care Home |
| <input type="checkbox"/> Homemaker-Home Health Aide Agency | <input type="checkbox"/> Rest Home with Nursing Supervision |
| <input type="checkbox"/> Hospice/19a-495-5a & 19-13-D1(C) | <input type="checkbox"/> In-Patient Hospice Unit |
| <input type="checkbox"/> Hospital for Mentally Ill Persons | <input type="checkbox"/> 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 Ave New Haven CT 06511 203-865-
Business Address City State Zip Code Telephone 5158

Same
Mailing Address (if applicable)

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

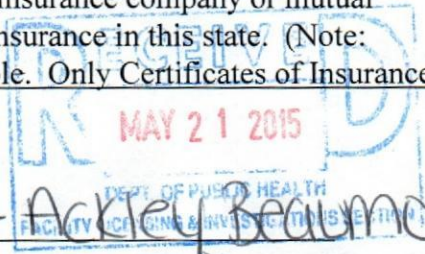
- | | |
|--|---|
| <input type="checkbox"/> Individual/Sole proprietor | <input type="checkbox"/> Municipality |
| <input type="checkbox"/> General Partnership | <input type="checkbox"/> Trust |
| <input type="checkbox"/> Limited Partnership | <input type="checkbox"/> Profit Corporation |
| <input type="checkbox"/> Limited Liability Company | |
| <input type="checkbox"/> Other: _____ | |
| <input checked="" type="checkbox"/> Non-profit Corporation | |



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

Judy Tabar 345 Whitney Ave 203-865-
Name Address Telephone 5158
New Haven, CT 06511

- 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

North United Methodist Church - Ackley Beaumont

Name	PO Box 320235 Hartford CT 06132				Telephone
Business Address	City	State	Zip Code		
1205 Albany Avenue					
Hartford, CT 06132					

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~~

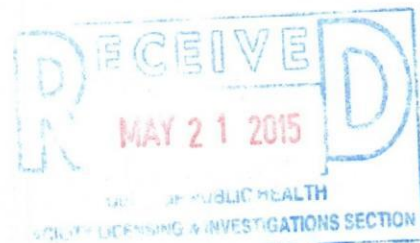
Board of Directors 2014-2015

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

FORM 3

FACILITY/AGENCY NAME: _____

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.**

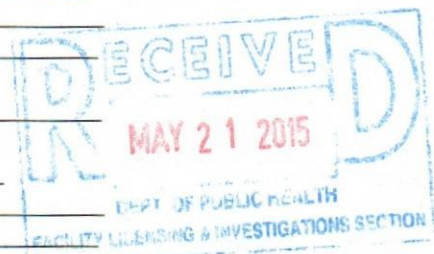
This information is for: Licensee attached
 Real Property Owner _____

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)
02/12/2015

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.accounts@marsh.com Fax: 212-948-1307 109210-NIPT-CAS-15-16	CONTACT NAME: PHONE (A/C, No, Ext): E-MAIL ADDRESS:	FAX (A/C, No):
	INSURER(S) AFFORDING COVERAGE	
INSURED PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC., AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. 345 WHITNEY AVENUE NEW HAVEN, CT 06511	INSURER A: N/A	NAIC # N/A
	INSURER B: National Union Fire Ins. Co. of Pittsburgh, PA	19445
	INSURER C:	
	INSURER D:	
	INSURER E:	

COVERAGES **CERTIFICATE NUMBER:** NYC-007010541-01 **REVISION NUMBER:** 1

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 SUBR INSR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> 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 <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$					EACH OCCURRENCE \$ AGGREGATE \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	<input type="checkbox"/> Y <input checked="" type="checkbox"/> N/A				<input type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
B	MEDICAL PROFESSIONAL CLAIMS-MADE COVERAGE		6793286 *Program Retro Date: 11/1/76*	01/01/2015	01/01/2016	PER CLAIM \$1,000,000 AGGREGATE \$3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
 EVIDENCE OF COVERAGE FOR HEALTH CENTER
Diana 860 380-3104



CERTIFICATE HOLDER PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND 1229 ALBANY AVENUE HARTFORD, CT 06112	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 <i>Ricki Fitzsimmons</i>
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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
01/07/2016

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.accounts@marsh.com Fax: 212-918-1307	CONTACT NAME: _____	
	PHONE (A/C, No, Ext): _____	FAX (A/C, No): _____
E-MAIL ADDRESS: _____		
INSURER(S) AFFORDING COVERAGE		NAIC #
109210-WC-5-5-16-17 NEW, C WC	INSURER A: N/A	N/A
INSURED PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC., AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. 345 WHITNEY AVENUE NEW HAVEN, CT 06511	INSURER B: ACE American Insurance Company	22667
	INSURER C: N/A	N/A
	INSURER D: _____	_____
	INSURER E: _____	_____
	INSURER F: _____	_____

COVERAGES **CERTIFICATE NUMBER:** NYC-007090688-05 **REVISION NUMBER:** 2

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 INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER: _____						EACH OCCURRENCE \$ _____ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ _____ MED EXP (Any one person) \$ _____ PERSONAL & ADV INJURY \$ _____ GENERAL AGGREGATE \$ _____ PRODUCTS - COM/PROP AGG \$ _____ \$ _____
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) \$ _____ BODILY INJURY (Per person) \$ _____ BODILY INJURY (Per accident) \$ _____ PROPERTY DAMAGE (Per accident) \$ _____ \$ _____
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$ _____						EACH OCCURRENCE \$ _____ AGGREGATE \$ _____ \$ _____
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N	N/A	RSC C48130549	01/01/2016	01/01/2017	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> 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 (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
 EVIDENCE OF COVERAGE.

CERTIFICATE HOLDER PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC. 1229 ALBANY AVENUE HARTFORD, CT 06112	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 <i>Ricki Fitzsimmons</i>
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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.

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PRODUCER Marsh USA, Inc. 1166 Avenue of the Americas New York, NY 10036 Attn: healthcare.accounts@marsh.com Fax: 212-948-1307	CONTACT NAME: PHONE (A/C, No, Ext): _____ FAX (A/C, No): _____ E-MAIL ADDRESS: _____	
	INSURER(S) AFFORDING COVERAGE	
109210-NIP-CAS-15-16 NEW,C GLPL	INSURER A: New Hampshire Insurance Company	NAIC # 23841
INSURED PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC. AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. 345 WHITNEY AVENUE NEW HAVEN, CT 06511	INSURER B: National Union Fire Ins. Co. of Pittsburgh, PA	19445
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES	CERTIFICATE NUMBER: NYC-006757681-27	REVISION NUMBER: 11
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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 <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> SIR: \$100,000 GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC			082695195	01/01/2015	01/01/2016	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMPIOP AGG \$ 2,000,000 \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input type="checkbox"/> RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below						WC STATUTORY LIMITS <input type="checkbox"/> OTH-ER <input type="checkbox"/> E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
B	MEDICAL PROFESSIONAL CLAIMS-MADE COVERAGE			6793286 Program Retro Date: 11/1/76	01/01/2015	01/01/2016	PER CLAIM \$1,000,000 AGGREGATE \$3,000,000

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

RECEIVED
MAY 21 2015
DEPT. OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

CERTIFICATE HOLDER PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND ATTN: LOUIS DENEGRÉ 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 <i>Ricki Fitzsimmons</i>
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State Of Connecticut

Hartford Fire Department
Fire Marshal's Office
253 High Street
Hartford, CT 06103
Main: (860) 757-4530 Fax: (860) 722-8249

On this Wednesday, November 18, 2015, the Hartford Fire Marshal's Office conducted a inspection/plan review of the following premises:

Planned Parenthood of S.N.E.
1229 Albany Av. 4th floor
Hartford, CT 06112

This inspection/plan review was used to determine the degree of compliance with the fire safety requirements of the Connecticut General Statutes Chapter 541 as authorized by Section 29-305 of the statutes. This facility was evaluated as:

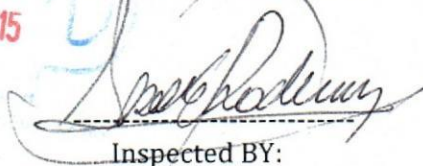
Medical (group B)

as classified by the CONNECTICUT FIRE SAFETY CODE. As a result of this inspection/plan review, the following conditions were found:

- I. At the time of inspection, no code violations were identified.
Certificate of approval recommended.
- II. At the time of inspection/plan review, conditions were discovered to be contrary to be minimum requirements of those codes. An acceptable plan of correction was submitted (see attached information).
Certificate of approval recommended.
- III. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. No approved plan of correction was submitted (see attached information).
Certificate of approval NOT recommended.
- IV. Based on the extreme hazard to the public safety discovered at the time of this inspection, this office is currently seeking an injunction from the court through our City Attorney for the purpose of closing or restricting usage of this facility by the public (see attached information).
Certificate of approval NOT recommended.



Fire Marshal


Inspected BY:

Thursday, November 19, 2015
Date

To: Christine Jennings, Processing Technician
Department of Public Health
410 Capital Ave
PO BOX 340308
Hartford, Ct 06134

From: Beth Murana, Acting Center Manager
Planned Parenthood of Southern New England
1229 Albany Ave
Hartford, Ct 06112

Date: 11/24/15

RE: Fire Marshal Report

Dear Ms. Jennings,

Please see enclosed the most recent fire marshal inspection for the facility indicated above.

Please contact me if you have any questions.

Sincerely,



Beth Murana, Acting Center Manager
Planned Parenthood Of Southern New England
1229 Albany Ave
Hartford, Ct 06112

RECEIVED
DEC 03 2015



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
Facility "d/b/a" (doing business as) Name
1229 Albany Ave Hartford CT 06112 860-728-0235
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 [] Abortion Procedures
[] Dental [] Mental Health Services

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

3. Erin Livensparger
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-11-6:45 W-9:00-4:45 F-8:30-4:15
T-9:30-4:15 TH-11-6:45 S-10-1:45
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.

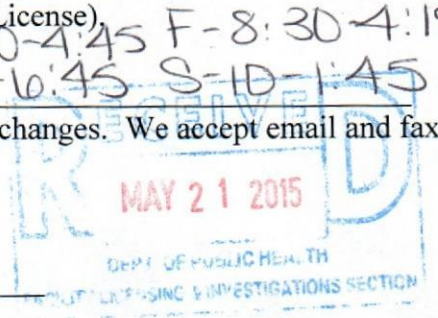
7. Business Fax Number: 860-728-0234

8. Business Email Address: erin.livensparger@ppsne.org

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

Signature of Administrator

5/6/15
Date Signed



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).**

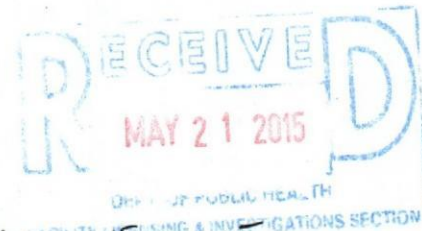
14. Affidavit of Owner:
I attest that the information provided within this application is true and accurate and that any changes in the information submitted will be reported to the Department as required by law.

Judy Tabak
Signature

5/18/15
Date Signed

Check one as applicable:

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



State of Connecticut)

May 18, 2015

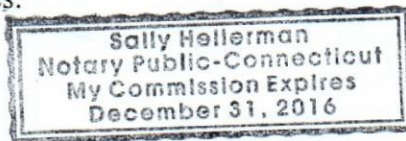
County of New Haven)

ss Connecticut 2015

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

Sally Hellerman
 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
- Pre-conception care
- Medication abortion services
- Health and sexual health education services
- Hepatitis and HPV services
- Transgender services
- Primary Care

