STATE OF CONNECTICUT

Department of Public Health

LICENSE

LICENSE NO. 000011

Family Planning

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 Parent of Southern New England, Inc. is hereby licensed to maintain and operate an Family Planning.

Planned Parenthood of Southern New England, Inc. is located at 26 Woman's Way, Meriden, CT 06451

This license expires March 31, 2019 and may be revoked for cause at any time. Dated at Hartford Connecticut April 1, 2015. RENEWAL



Jewel Mullen, MD, MPH, MPA

Jawel Mullen Ms

Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0011

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

Planned Parenthood Of Connecticut, Inc.-Health Center is located at 26 Woman'S Way, Meriden, CT 06451.

This license expires March 31, 2011 and may be revoked for cause at any time.

Dated at Hartford, Connecticut, April 1, 2007. RENEWAL.



& Robert Dolvin M.D., M.R.K.



[] INITIAL

STATE OF CONNECTICUT

Page 1 of 4

DEPARTMENT OF PUBLIC HEALTH FACILITY LICENSE & INVESTIGATIONS SECTION

LICENSURE APPLICATION

[] CHANGE OF OWNERSHIP [] RELOCATION

| RENEWAL

| part (10% adm directorists the a | CE: Any nursing home licensee, owner or officer, including t limited to, a director, trustee, limited partner, managing er, general partner or any person having at least 10 per cent ownership interest, and any administrator, assistant istrator, medical director, director of nursing or assistant or of nursing, may be subject to criminal liability, in additional and administrative sanctions under federal and state law, fouse or neglect of a resident of the nursing home perpetrated employee of the nursing home. | 1 |
|--|---|---|
| | A separate application must be completed for each licensed level of care, or not, that level is located at the same address | |
| 1. | Planned Parenthoud of Southern New England cility "d/b/a" (doing business as) Name | |
| (| siness Address City State Zip Code Telephone | |
| | illing Address (if applicable) City State Zip Code | |

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? [VYES []] NO



Federal Employer Identification Number

Phone: (860) 509-7444 <u>Telephone Device for the Deaf (860) 509-719</u> 410 Capitol Avenue - MS # 12HFL

P.O. Box 340308 Hartford, CT 06134

An Equal Opportunity Employer

2.

| In acce | ordance with Section 19a-491 by made for a license to opera | and/or Section 19a-50 ate the following (plea | 06 of the ase check | Connecticut (the appropria | General Statutes, applicate box that applies): | ation |
|---|--|--|---|--|--|--------|
| []C []C []C []F []G []H []H | Assisted Living Services Agend Children's Hospital Chronic and Convalescent Nurse Chronic Disease Hospital Samily Planning Clinic General Hospital Home Health Care Agency Homemaker-Home Health Aide Hospice/19a-495-5a & 19-13-D Hospital for Mentally III Person | [] Ma sing Home [] Ma [] Ou [] Ou [] Ou [] Reserved [] Reserved [] In- | aternity H aternity H atpatient C atpatient I atpatient S esidential est Home | Iome Iospital Clinic/Primary Dialysis Unit Surgical Facili Care Home with Nursing Iospice Unit | ty | |
| 4. | Bed Capacity Requested (if a please list the bed capacity for | applicable). If submittor each level of care b | ting this a | application for lested. | multiple levels of care | , |
| | Level of Care | Beds/ Hemodialysis Statio | <u>ons</u> | Bassinets (if | applicable) | |
| | | | | | | |
| 5. | Disclose the legal entity wh i entity.) | ich owns/operates th | e facility | . (Note: The | license will be issued to | o this |
| | Planned Parent | noud of Sa | ather | n New 8 | England | |
| | 345 Whitney Are Business Address | New Haven City | State | CloS11 Zip Code | 203 865 5158 Telephone | |
| | Same Mailing Address (if applicab | le) | | | | |
| 6. | Is the above named legal entit | ty a (please check the | box which | ch applies): | | |
| | [] Individual/Sole proprietors [] General Partnership [] Limited Partnership [] Limited Liability Compa [] Other: [] Non-profit Corporation | | [] Tr | unicipality rust ofit Corporati | on 1 1 2015 | |
| 7. | Please disclose the name, bus Licensee. | | | | | e |
| | Name 1 Abar 345 u | Address | w Have | n, ct (Vesi) | 23.805.5158 Telephone | |

FLIS LICAPP -001 Rev. 4/14

- 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 <u>corporation</u> (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.
 - 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 Prop | erty EMICNO | ICI T. | Phillips | | |
|-----|------------------------------------|----------------|----------------|-----------|--------|-------|
| | Name 12 COSC STVC Business Address | et Suite | 207 N State | Zip Code | Telepl | 00300 |
| | Business radiess | City | State | (D)16 | CISI | 20:5 |
| | | | | on market | | |

FOR OFFICE USE ONLY

| | CHECK # | AMOUNT \$ |
|------|--|--|
| | DATE RECEIVED | INITIALS |
| **** | *********** | ************* |
| 13. | Marshal. NOTE: <u>Hospitals</u> must have completed for each building on the holicense. Additional forms may be cop- | spection Form (attached) must be completed by the Local Fire e a separate Fire Marshal's Certificate of Inspection ospital's campus and each satellite listed on the hospital's pied if necessary. Each completed Fire Marshal's pied must have an original signature. (Not applicable for the Health Agencies). |
| 14. | | ithin this application is true and accurate and that any changes ported to the Department as required by law. |
| | Signature Jakan | 2/3/2015 Date Signed |
| | Check one as applicable: | |
| | [] Individual/Sole Proprietor [] General/Managing Partner [] President of Corporation [] Secretary of Corporation [] Municipal Officer [] Trustee | D) * Cally al |
| | State of Connecticut) | FEB 1 1 2015 |
| | County of New Haver) | ss 2/3 20_15 |
| | Personally appeared before me the above to the truth of the statements contained | in his/her answers to the foregoing questions. Sulf Affella Notary Public [T |
| | | Justice of the Peace [] Town Clerk |
| | (If Notary Public) | Commissioner of the Superior Court [] |

Attachment 1



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH FACILITY LICENSING & INVESTIGATIONS SECTION

FORM 1

| FACI | LITY/AGENCY NAME: | |
|--------|--|-------------------------|
| | 1 must be completed if the facility/agency is owned/operated diability company. Please copy additional sheets if necessary | |
| | ach partner or manager with a 10% or greater ownership interest nation requested below. Please complete a separate form for or | |
| This i | nformation is for: Licensee Real Property Owner | |
| 1. | | |
| 1. | Name: | |
| | Address: | |
| | Telephone: | |
| | [] Manager [] General Partner | [] Limited Partner |
| | Partner's/Manager's percentage of ownership: | |
| 2. | Name: | |
| | Address: | |
| | | |
| | Please indicate the category which best describes this entity: | |
| | [] Manager [] General Partner | [] Limited Partner |
| | [] Manager [] General Partner Partner's/Manager's percentage of ownership: | |
| 3. | Name: | |
| | Address: | |
| | Telephone. | |
| | Please indicate the category which best describes this entity: | |
| | [] Manager [] General Partner Partner's/Manager's percentage of ownership: | [] Limited Partner |
| | | |
| 4. | Name: | |
| | Address: | |
| | Please indicate the category which heat describes this autitus | |
| | [] Manager [] General Portner | [] Limited Destruction |
| | Partner's/Manager's percentage of ownership | [] Limited Partner |
| | [] Manager [] General Partner | [] Limited Partner |
| | Address: Telephone: Please indicate the category which best describes this entity: [] Manager | C) SELVE |
| | | FEB 11 200 |

Attachment 3



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH FACILITY LICENSING & INVESTIGATIONS SECTION

FORM 3

| FAC | LITY/AGENCY NAME: |
|------|--|
| | 3 must be completed if the facility/agency or Real Property Owner is owned/operated by a corporation (profit or profit). Please copy additional sheets if necessary. |
| owne | ach stockholder with a 10% or greater ownership interest in the Licensee, provide the information requested below. If no rowns 10% or more of the total shares, please indicate the two largest stockholders. Please complete a separate form for legal entity listed below that is not an individual. |
| This | nformation is for: Licensee See 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: FEB 11 20:5 |
| | |

| | - | _ | _ | |
|---|---|---|---|---|
| | _ | - | - | b |
| A | | | K | D |
| | | _ | - | |

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 INCLINED, the policyline must be endersed. If SURDOCATION IS WANTED subject to

| PRODUCER Marsh USA, Inc. | CONTAC NAME: | т | Al data some | | |
|---|---|--------------------------------------|---------------------|--|------------|
| 1166 Avenue of the Americas | PHONE (A/C, No E-MAIL | Ext): | | FAX (A/C, No): | |
| New York, NY 10036 | E-MAIL. | S: | | | |
| Attn: healthcare.accountscss@marsh.com Fax: 212-948-1307 | | IN | SURER(S) AFFOR | RDING COVERAGE | NAIC# |
| 109210-NIP-CAS-15-16 NEW,C GLPL | INSURE | RA: New Ham | pshire insurance (| Company | 23841 |
| NSURED PLANNED PARENTHOOD OF SOUTHERN NEW | INSURE | R B : National I | Jnion Fire Ins. Co. | of Pittsburgh, PA | 19445 |
| ENGLAND, INC. | INSURE | RC: | | | |
| AN AFFILIATE OF PLANNED PARENTHOOD | INSURE | RD: | | | |
| FEDERATION OF AMERICA, INC. 345 WHITNEY AVENUE | INSURE | RE: | | | |
| NEW HAVEN, CT 06511 | INSURE | | | | |
| COVERAGES CERTIFICATE NUMBER: | | 005757681-27 | | REVISION NUMBER: 11 | • |
| THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BE INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR COI CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE EXCLUSIONS AND CONDITIONS OF SUCH POLICIES, LIMITS SHOWN MATER TO THE POLICY OF SUCH POLICIES, LIMITS SHOWN MATER TO THE POLICY OF SUCH POLICIES, LIMITS SHOWN MATER TO THE POLICY OF SUCH POLICY | NDITION OF ANY AFFORDED BY T AY HAVE BEEN R | CONTRACT THE POLICIT EDUCED BY | OR OTHER I | DOCUMENT WITH RESPECT TO D HEREIN IS SUBJECT TO ALL | WHICH THIS |
| | | | | LIMITS | 1,000,00 |
| 1 | | 01/01/2015 | 01/01/2016 | EACH OCCURRENCE \$ DAMAGE TO RENTED | 1,000,00 |
| Goldmin Grand Charles | | | | PREMISES (Ea occurrence) \$ | 100,00 |
| CLAIMS-MADE | | | | MED EXP (Any one person) \$ | 1,000,00 |
| A 1011. \$100,000 | 1 | | 1 | PERSONAL & ADV INJURY \$ | 2,000,00 |
| | | | | GENERAL AGGREGATE \$ | |
| GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO: X Loc | | | 1 | PRODUCTS - COMP/OP AGG \$ | 2,000,00 |
| POLICY JECT A LOC | | | | COMBINED SINGLE LIMIT | - working |
| | | | | (Ea accident) \$ BODILY INJURY (Per person) \$ | |
| ANY AUTO ALL OWNED SCHEDULED | | | | BODILY INJURY (Per accident) \$ | |
| AUTOS AUTOS NON-OWNED | | | | PROPERTY DAMAGE | |
| HIRED AUTOS AUTOS | | | | (Per accident) \$ | |
| UMBRELLA LIAB OCCUR | | | | | |
| - CHOROLINA - OCCOR | | | | EACH OCCURRENCE \$ | |
| OCAIMO-MACE | | | | AGGREGATE \$ | |
| DED RETENTION \$ WORKERS COMPENSATION | | | | WC STATU- OTH- TORY LIMITS ER | |
| AND EMPLOYERS' LIABILITY | | | | | |
| ANY PROPRIETOR/PARTNER/EXECUTIVE T/A OFFICER/MEMBER EXCLUDED? (Mandatory In NH) | | | | E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ | |
| (Manuacory in Nr) If yes, describe under DESCRIPTION OF OPERATIONS below | | | | | |
| B MEDICAL PROFESSIONAL 6793286 | | 01/01/2015 | 01/01/2016 | PER CLAIM | \$1,000,00 |
| | 1 | 01/01/2013 | 01/01/2010 | | |
| CLAIMS-MADE COVERAGE Program Retro Date: 1 | 11/1/76 | | | AGGREGATE | \$3,000,00 |
| ESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional | ni Remarks Schedule, | If more space | ls required) | FEB 17 2915 | ř. |
| CERTIFICATE HOLDER PLANNED PARENTHOOD OF SOUTHERN NEW | | ELLATION | | | |
| ENGLAND ATTN: LOUIS DENEGRE 345 WHITNEY AVENUE NEW HAVEN, CT 08511 | AUTHOR | EXPIRATION ORDANCE WE RIZED REPRES | N DATE THE | DESCRIBED POLICIES BE CANCE EREOF, NOTICE WILL BE D CY PROVISIONS. | |
| | of Mars | h USA Inc. | | Will Fit | |
| | | itzsimmons | | | |



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).

| certificate holder in lieu of such endorsement(s). | | | | | |
|---|--|----------------------------|----------------------------|--|--------------|
| PRODUCER Marsh USA, Inc. | CONT | : | | | |
| 1166 Avenue of the Americas | PHON (A/C, N | lo, Ext): | | FAX (A/C, No): | |
| New York, NY 10036 | E-MAII ADDR | | | | |
| Attn: healthcare.accountscss@marsh.com Fax: 212-948-1307 | | | SURER(S) AFFOR | RDING COVERAGE | NAIC # |
| 109210-WC-5-5-15-16 NEW,C WC | INSUR | ERA: N/A | | | N/A |
| NSURED | INSUR | ER B . ACE Ame | erican Insurance Co | ompany | 22667 |
| PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC., AN AFFILIATE OF PLANNED | | ERC: N/A | | | N/A |
| PARENTHOOD FEDERATION OF AMERICA, INC. | INSUR | | | | |
| 345 WHITNEY AVENUE | | | | | |
| NEW HAVEN, CT 06511 | INSUR | | | | |
| COVERAGES CERTIFICATE NUMBI | INSUR | | | DEVISION NUMBER: 2 | |
| THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE L | | C-006791919-04 | O THE INCHES | REVISION NUMBER: 3 | OLICY BEBIOD |
| INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSIEXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS S | M OR CONDITION OF AN URANCE AFFORDED BY | THE POLICI | T OR OTHER | DOCUMENT WITH RESPECT TO AL | O WHICH THIS |
| NSR TYPE OF INSURANCE ADDL SUBR INSR WVD | POLICY NUMBER | POLICY EFF (MM/DD/YYYY) | POLICY EXP (MM/DD/YYYY) | LIMITS | |
| GENERAL LIABILITY | | | | EACH OCCURRENCE \$ | |
| COMMERCIAL GENERAL LIABILITY | | | | DAMAGE TO RENTED | |
| CLAIMS-MADE OCCUR | | | | PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ | |
| 30000 | | | | PERSONAL & ADV INJURY \$ | |
| | | | | | |
| GEN'L AGGREGATE LIMIT APPLIES PER: | | | | GENERAL AGGREGATE \$ | |
| PRO. | | | | PRODUCTS - COMP/OP AGG \$ | |
| POLICY JECT LOC AUTOMOBILE LIABILITY | | | | COMBINED SINGLE LIMIT | |
| | | | | (Ea accident) \$ | |
| ANY AUTO ALL OWNED SCHEDULED | | | | BODILY INJURY (Per person) \$ | |
| AUTOS AUTOS NON-OWNED | | | | BODILY INJURY (Per accident) \$ PROPERTY DAMAGE | |
| HIRED AUTOS AUTOS | | | | (Per accident) \$ | |
| | | | | S | |
| UMBRELLA LIAB OCCUR | | | | EACH OCCURRENCE \$ | |
| EXCESS LIAB CLAIMS-MADE | | | | AGGREGATE \$ | |
| DED RETENTION\$ | | | | s | |
| WORKERS COMPENSATION AND EMPLOYERS' LIABILITY | | | | X WC STATU- TORY LIMITS ER | |
| ANY PROPRIETOR/PARTNER/EXECUTIVE N N/A RSC C481 | 28865 | 01/01/2015 | 01/01/2016 | E.L. EACH ACCIDENT \$ | 1,000,0 |
| (Mandatory in NH) | | | | E.L. DISEASE - EA EMPLOYEE \$ | 1,000,0 |
| If yes, describe under DESCRIPTION OF OPERATIONS below | | | | E.L. DISEASE - POLICY LIMIT \$ | 1,000,0 |
| | | | | | |
| | | | | | |
| ESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 10: VIDENCE OF COVERAGE. | 1, Additional Remarks Schedul | e, if more space | is required) | CEUVEI | |
| | | | IN F | EB 11 20:5 | |
| | | | THE PER STREET | the same of the same of | |
| ERTIFICATE HOLDER | CAN | CELLATION | | the wind you | |
| PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC. 26 WOMEN'S WAY MERIDEN, CT 06451 | THE | EXPIRATIO | N DATE THE | ESCRIBED POLICIES BE CANCE EREOF, NOTICE WILL BE D Y PROVISIONS. | |
| | | ORIZED REPRES | ENTATIVE | | |
| | Ricki | Fitzsimmons | | Rich. Fitz | |
| | HICKI | | | act. The | |

Department of Public Safety Division of Fire, Emergency & Building Services Office of State Fire Marshal



STATE OF CONNECTICUT

| On (date) June 19, 2014 , the (town/City) Meriden Office of the Fire Marshal |
|--|
| Conducted an inspection of (name of facility) Planned Parenthood, |
| Located at (address)26 Women's Wayin the |
| City/Town of to determine the degree of compliance with the |
| Fire safety requirements of Connecticut General Statues Chapter 541 as authorized by |
| Section 29-305 of the statutes. This facility was evaluated as a (new/existing) existing |
| (occupancy classification) Business as classified |
| by the CONNECTICUT FIRE SAFETY CODE. As a result of this inspection, 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, conditions were discovered to be contrary to the minimum requirements of these codes. Certificate of approval recommended. |
| III. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. Certificate of approval <u>not</u> recommended. |
| IV. Based on the extreme hazard to public safety discovered at the time of this inspection, this office is currently seeking an injunction from the court through our Town/City Attorney for the purpose of closing or restricting usage of this facility by the public. Certificate of approval not recommended. FEB 11 2035 |
| All the second of the second o |
| LI Charles |
| John Yacovino, Deputy Fire Marshal Date |
| City or Town Meriden . |



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

| Ple | ease respond to all of the following questions: |
|-----|--|
| 1. | Planned Paventhood of Southern New England Facility "d/b/a" (doing business as) Name |
| | 20 Women's Way Menden (T 0045) (28) 238-318 Business Address City State Zip Code Telephone |
| 2. | Check the appropriate box/boxes describing the services to be provided by the clinic: [] Primary Care |
| Be | e advised that mental health services does NOT include Substance Abuse Services. |
| 3. | Samontha Doloson Administrator (Your name needs to appear as it is shown on your Professional License). |
| 4. | Medical Director Dental Director (if applicable) (Your name needs to appear as it is shown on your Professional License). M-8:30-4:15 T-11:00-0:45 W-9:30-4:15 |
| 5. | Days & Hours of Operation: TH - 8: 30-6:45 F-8:30-4:15 S-8:30-12:15 |
| Y | ou 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) 238 – 3182 |
| 8. | Business Email Address: Samantha dobson Copone ova |
| 9. | Business Cell Phone Number with Texting capabilities of the Administrator: |
| _ | Signature of Administrator Date Signed |
| | Signature of Administrator Date Signed |

Planned Parenthood of Southern New England

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.

Frances Padilla

Amelia Renkert-Thomas

Susan Ross



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

FEB 1123

| | | | HEALTH CENTER ST - January 12, 2015 | | | |
|-----------------------------|--|--|---|---|--|--|
| | BRIDGEPORT | _ | | Caitlin Murahy | HARTFORD NORTH | Sandy Dowell |
| CLINICIAN CAGER | Laure Haydu Linda Magee | Antonietta Schaalman Jennifer Ryan Joan Welch, PD | Lisa Marie Griffiths, PD | Christina Fantoni, PD Amy Kenefick, PD | Lucinda Canty, PD Laura Kattan, PD | Samantha Hyacinth Diane Libby-Ramage Maria Banevicius, PD |
| RN | | | | | Elaine Robinson | Bridget Tomczak |
| NROLLMENT SPECIALIST | Mayce Torres | 4 | Dichard Morrous | Nathan Dorian | Rosa Rodnguez | Samantha DeAndelis |
| ۹. | Latisha Ervin (Float) Omar Jehaludi Nikole Moya Gina Porto Tanisa Paulding PD | Dana Almonte | Northand Montow Shen Saddlemire Brittany Schultz, PD Jessa Goldstein, PD | Narrian Monique Mokkay Claudia Valderrama | Melanie Vazquez | Sariantia Coviguia Fernanda Formel Brianne Johnson |
| ADVANCED GA | Freign Cuevas* Lori Gall Aida Orlega* Amber Bachman, PD | Jennifer Tomasini | Jacklyn Michalski, PD | Jennifer Bouley, PD | Jenny Martorelli Yolanda Young | Norimar Nieves* Nicolette Laume, PD |
| REGIONAL DIRECTOR | Shira Revzen | (OPEN) | (OPEN) | (OPEN) | (OPEN) | (OPEN) |
| | MERIDEN/NEW BRIT | NEW HAVEN | NEW LONDON | NORWICH | OLD SAYBROOK | PROVIDENCE |
| ENTER MANAGER | Samantha Dobson | Jody Clark | Lauren Pereira | Janeen Ortiz* | Sara Culver | Danna Freedman-Shara |
| GLINICIAN | Kathy Bryson Loren Fields Kris Sterling Jenna LoGiudice, PD | Carrie Ferrigno Janet Gumaer Diana Kavanagh Wei-Ti Chen, PD Gina Novick, PD Leslie Robinson, PD Margaret Writhington, PD | Sarah Whalen Edie Morren-Morrison, PD | Kris Robin Stephanie Malia, PD | Elizabeth Fabrizi | Statop Ramsey Jessica Wilder Willa Carter, PD Monstance Chang, PD Megan Gaynor Charette, PD Kristina Shepherd, PD |
| RN | | LaToya Ward Sarah Acker, PD Sari Gottlieb-Sherman, PD | | Hannah Lakehomer, PD | | Paula Golden Meghan Henry, PD |
| LPN | Daiva Morales* | | | Katie Arendt | | |
| ENROLLMENT SPECIALIST | Madeline Martinez | | | | | |
| CA | Stephanie Colon Stephanie Protette | Amanda Bradley Hector Cotto Chelsea Epps Tiffany Marin Mercy Plant | Tylisha Wrighten | Hannah Carey Emily Kersey Stephen Polach Jessica Stefanski | Jessica Bennett-Michael (Float) | Sarah Bramblet Sarah Bramblet Jackyn Dos Reis Brianna Jolaoso Kayla Murphy Amber Newmann Tara Patterson Pam Shaw Ashley Silva Harriet Singer Adina Riggins, PD Nindi Tlemo, PD |
| ADVANCED CA | Viviana Hernandez* Tina St. Germain Jose Vargas | Victoria Burch Omara de la Cruz* Candice Langley Casandra Lehr | Bernadette DeShields Damaris Hemandez* Veronica Sohn | Donna Bonanno Jessica Davila* | Nicole Abbott Susan Schlachter | Antigone Reyes Esperanza Santana* Eni Valerio* |
| DECICANAL DIDECTOR | Shira Berran | Carmen Trochez* | (OPEN) | Shira Revzen | (OPEN) | Shira Revzen |
| EGIOTAL DIRECTOR | - Carrier | NOTOMINGTON | WATERRIRY | WEST HARTFORD | WILLIMANTIC | |
| CENTER MANAGER CLINICIAN | Doris Walden Garnon Ward Ines Riera, PD Susan Ruehl, PD | Tammy Hreha Claudette Baril Barla Bishop, PD | Alicia Caban* Ronnie Dubrowin* Karen Parkhurst, PD | Jane Yousman Mark Plerce Chloe Quinn Emily Cote, PD | Beth Murana Jill Cassells | |
| RN | Alison Lomas Ashley Plummer, PD | | 2 | Kate Sivel Der asquare, FD Kate Sivel Samantha Tamulis, PD Casev Vizenor PD | | |
| V S | Nasia Frataroli Digna Guadalupe Devlynn Hresko Melina Rankine Nathanaela Raymond Catherine Osorio, PD Sandra Pinto, PD | Jennifer Helt Heather Keyes | Karigna Santos Claudia Waller | Jetsebel Lopez Morayma Rodnguez Brenda Samuels | Shallyn O'Connell Franceska Vega Jillan Librandi, PD | |
| | | Jasmine Osorio | Erika Vanamringe Ivelisse Vasquez* | Madeline Alvarez* Mary Cruz* Getzenia Nieves* Kaitin Sohn, PD | Lillian Morales* | |
| REGIONAL DIRECTOR | Shira Revzen | (OPEN) | (OPEN) | Shira Revzen | (OPEN) | 7 |

March 2011

RENEWAL



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH FACILITY LICENSE & INVESTIGATIONS SECTION

LICENSURE APPLICATION

[] INITIAL RENEWAL

NOTE: A separate application must be completed for each licensed level of care which is located at a different address. One (1) application may be submitted for multiple levels of care provided each level of care has the same name and the same licensee and is located at the same address.

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/boxes that apply):

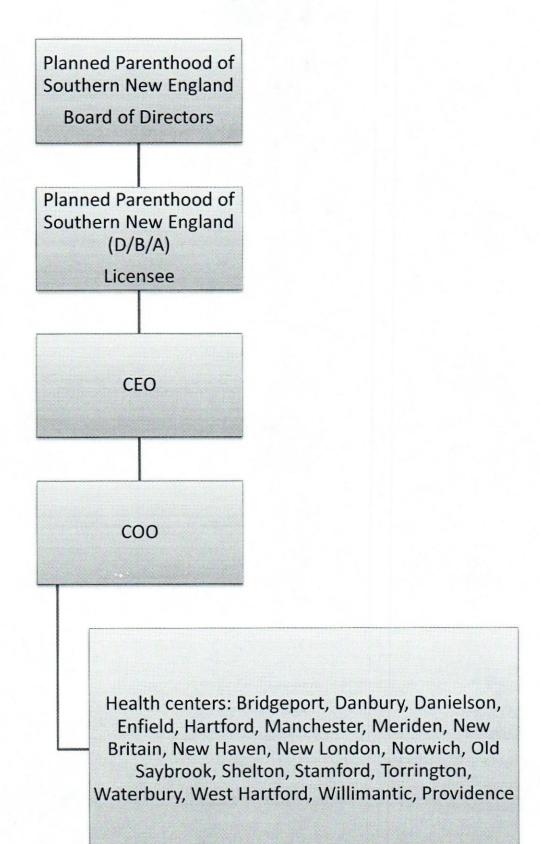
| Assisted Living Services Agency | Infirmary Operated by an Educational Institution |
|---|--|
| [] Children's Hospital | Maternity Home |
| [] Chronic and Convalescent Nursing Home | [] Maternity Hospital |
| [] Chronic Disease Hospital | Outpatient Clinic |
| Family Planning Clinic | Outpatient Dialysis Unit |
| [] General Hospital | Outpatient Surgical Facility |
| [] Home Health Care Agency | [] Residential Care Home |
| [] Homemaker-Home Health Aide Agency | [] Rest Home with Nursing Supervision |
| [] Hospice | [] Well Child Clinic |
| [] Hospital for Mentally Ill Persons | Mental Health Day Treatment |
| [] Mental Health Psychiatric OutPat. | [] Mental Health Community Residence |
| [] Mental Health Intermediate Tmt. | [] Mental Health Residential Living |
| [] Substance Abuse & Dependence | |
| | 6 6 6 |
| Di la li Cil Cil i | |
| Please respond to all of the following questions: | シ語 A 5 11 11 11 11 11 11 11 11 11 11 11 11 1 |
| I Planned tannet | mond of Conthana transformer |
| Tarility "d/h/a" (daing hydings ag) Name | Valor of Svolvali Many Crape |
| Facility "d/b/a" (doing business as) Name | (Mexideno) |
| 210 Momen's Wa | 1 Meriden (T. NoUS) |
| Business Address City | State Zip Code Telephone |
| Business Address City | State Zip Code Telephone |
| same as | anne. |
| Mailing Address (if applicable) City | State Zip Code |
| | |



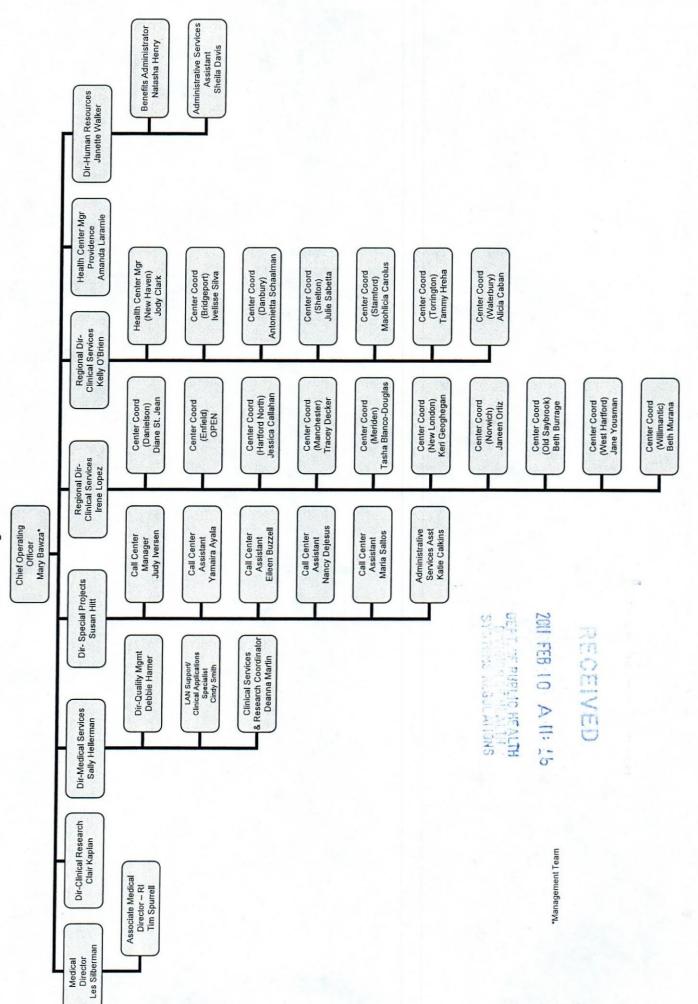
Phone: (860) 509-7444 <u>Telephone Device for the Deaf (860) 509-719</u> 410 Capitol Avenue - MS # 12HFL

P.O. Box 340308 Hartford, CT 06134

An Equal Opportunity Employer



Planned Parenthood of **Inthein New England** Chief Operating Officer January 2011





Serving Connection and Rhade Island

BOARD OF DIRECTORS, 2011-2012

OFFICERS:

Amelia Renkert-Thomas, Chair Nancy Hutson, Vice Chair Sandra Arnold, Secretary Slw de Gysser, Treasurer Niloy Sanyal, Assistant Treasurer

BOARD OF DIRECTORS:

Bennie Fleming
Delores Greenlee
Sue Hessel
Jeannette Ickovics
Valerie Seilling Jacobs
Simone P. Joyaux
Susann Mark
Kay Maxwell
Nadesha Mijoba
Donna Moffly
John R. Morton, M.D.
Shannon Perry
Fahd Vahidy

PPSNE Board of Directors May 2010-May 2011

OFFICERS

Kay Maxwell, Chair Connie Worthington, Vice Chair Maria Cruz-Saco, Ph.D., Secretary Amelia Renkert-Thomas, J.D., Treasurer Sandra Arnold, Assistant Treasurer

BOARD OF DIRECTORS

Charles S. Craig
Siw de Gysser
Bennie Fleming, Ed.D.
Delores Greenlee
Sue Hessel
Nancy Hutson, Ph.D.
Jeannette Ickovics, Ph.D.
Valerie Seiling Jacobs
Simone P. Joyaux, ACFRE
Rev. Maria LaSala
Donna Moffly
John R. Morton, M.D.
Shannon Perry
Niloy Sanyal
Richard Sugarman

2011 FEB 110 A 11: 15

| 2. | | applicable). If submitting thi for each level of care being re- | s application for multiple levels of care, quested. |
|------------------|---|--|--|
| 2/8 | Level of Care | Beds/ Hemodialysis Stations | Bassinets (if applicable) |
| | | | |
| √ ₃ . | OG - 0242 Federal Employer Identifica | | |
| 4. | Disclose the legal entity whitentity.) | ich owns/operates the facility. | (Note: The license will be issued to this |
| | Planned Pave Licensee | inthood of South | nern New England, Inc. |
| | 345 Whitney Business Address | Ave, New Haver City State | Zip Code Telephone (203)865-5(58) |
| | Mailing Address (if applical | ole) | (0 C N |
| √5. | Is the above named legal en | tity a (please check the box w | hich applies): |
| | [] Individual/Sole proprie [] General Partnership [] Limited Partnership [] Limited Liability Comp [] Other: [] Non-profit Corporation | tor []] []] pany | hich applies): Municipality Trust Profit Corporation |
| √6. | | athorized by the Office of the nsidered in Good Standing? [| Secretary of State to transact business in the YES [] NO |
| $\sqrt{7}$. | T . | | number of the Agent for Service for the Ohithey Ave, New Haven, CT Telephone 20511 (203) 865-5158 |
| √ ₈ . | Attach an organizational chalicensee's relationship with | art which reflects the current of | ownership structure of the ficensee and the |
| | | DACH ITHE | VII (202) 129-5085 |

FLIS LICAPP -001 Rev. 3-06

- 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 <u>trust</u>, 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 <u>corporation</u> (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 <u>and</u> 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 When and Families Center |
|------|---|
| | Name 9 Colony Street Merlidan, CT. 06451 |
| | Business Address City State Zip Code Telephone 203-355-9297 |
| 1. | Contact: Patricia Lagner. ext. 33 |

Annual Fire Marshal's Certificate of Inspection Form (attached) must be completed by the Local Fire Marshal. NOTE: <u>Hospitals</u> 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 ALSA's, Homemaker Home Health and Home Health Agencies).

Page 3 of 4

- 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.
 - Attach a list including the name, address and telephone number of all trustees.
 - C. If the Licensee is a <u>corporation</u> (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.
 - 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 A Families Centre |
|-----|---|
| | Name 9 Colony Street Maridan CT. 16451. |
| | Business Address City State Zip Code Telephone 343-357-9297 |
| | 11/1/17/17 . PACIFICATION (1000 0). |
| 13 | Annual Fire Marshal's Certificate of Inspection Form (attached) must be completed by the Local Fire |

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 ALSA's, Homemaker Home Health and Home Health Agencies).



DATE (MWDDYYYY) 12/24/2010

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 EPRESENTATIVE 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. | CONTACT NAME: | NAME: | | | | | |
|--|---|--------|--|--|--|--|--|
| 1166 Avenue of the Americas New York, NY 10036 | PHONE FAX (A/C, No. Ext): (A/C, | N-1 | | | | | |
| | E-MAIL ADDRESS: | NO): | | | | | |
| | PRODUCER CUSTOMER ID #: | | | | | | |
| | INSURER(S) AFFORDING COVERAGE | NAIC # | | | | | |
| INSURED PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC. AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. 345 WHITNEY AVENUE | INSURER A : Markel Insurance Company | 38970 | | | | | |
| | INSURER B: National Union Fire Ins. Co. of Pitlsburgh, PA | 19445 | | | | | |
| | INSURER C ; | | | | | | |
| | INSURER D: | | | | | | |
| NEW HAVEN, CT 06511 | INSURER E : | | | | | | |
| | INSURER F: | | | | | | |

COVERAGES CERTIFICATE NUMBER: NYC-004978510-22 REVISION NUMBER: 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,

| 13R | TYPE OF INSURANCE | INSR | SUER | POLICY NUMBER | POLICY EFF (MM/DD/YYYY) | POLICY EXP | LIMIT | E7 | |
|-----|--|------|------|------------------------|----------------------------|------------|---|----|-----------|
| A | GENERAL LIABILITY | | | 3C40359 | 01/01/2011 | 01/01/2012 | EACH OCCURRENCE | s | 1,000,000 |
| | X COMMERCIAL GENERAL LIABILITY | | | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) | s | 100,000 |
| | CLAIMS-MADE X OCCUR | | | | | | MED EXP (Any one person) | 5 | 5,000 |
| | X SIR: \$100,000 | | | | | | PERSONAL & ADV INJURY | \$ | 1,000,000 |
| | | | | | | | GENERAL AGGREGATE | 5 | 2,000,000 |
| | GEN'L AGGREGATE LIMIT APPLIES PER: | | | | | | PRODUCTS - COMP/OP AGG | s | 2,000,000 |
| | POLICY PRO- X LOC | | | | | | | \$ | |
| | AUTOMOBILE LIABILITY | 2 | | | | | COMBINED SINGLE LIMIT (Ea accident) | ş | |
| | ANY AUTO | | | | | | BODILY INJURY (Per person) | 5 | |
| | ALL OWNED AUTOS | | | | | | BODILY INJURY (Per accident) | \$ | |
| | SCHEDULED AUTOS HIRED AUTOS | | | | | | PROPERTY DAMAGE (Per accident) | s | |
| | NON-OWNED AUTOS | | | | | | | \$ | |
| | 4.31 (18) (18) (18) (18) (18) (18) (18) (18 | | | | | | | S | |
| | UMBRELLA LIAB OCCUR | 6 | | | | | EACH OCCURRENCE | 2 | |
| | EXCESS LIAB CLAIMS-MADE | | | | | | AGGREGATE | 5 | |
| | DEOUCTIBLE | | | | | | | \$ | |
| | RETENTION \$ | | | | | | | 5 | |
| | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY | | | | | | WC STATU- OTH- | | |
| | ANY PROPRIETOR/PARTNER/EXECUTIVE | N/A | | | | | E.L. EACH ACCIDENT | 5 | |
| | (Mandatory In NH) | | | | | | E.L. DISEASE - EA EMPLOYEE | 5 | |
| | If yes, describe under DESCRIPTION OF OPERATIONS below | | | | | | E.L. DISEASE - POLICY LIMIT | \$ | |
| 3 | MEDICAL PROFESSIONAL | | 1 | 6793286 | 01/01/2011 | 01/01/2012 | PER CLAIM | | 1,000,000 |
| | CLAIMS-MADE COVERAGE | | | Program Retro: 11/1/76 | | | AGGREGATE | | 3,000,000 |

| CERTIFICATE HOLDER | CANCELLATION | | | |
|---|--|--|--|--|
| PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND N: LOUIS DENEGRE | SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. | | | |
| WHITNEY AVENUE NEW HAVEN, CT 06511 | AUTHORIZED REPRESENTATIVE of Marsh USA Inc. | | | |
| | Christian Victorino | | | |



DATE (MWDD/YYYY) 12/23/2010

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. PHONE
(A/C, No. Ext):
E-MAIL
ADDRESS:
PRODUCER
CUSTOMER ID # 1166 Avenue of the Americas New York, NY 10036 NAIC# INSURER(S) AFFORDING COVERAGE INSURER A: Continental Casualty Company 20443 INSURED PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC. AN AFFILIATE OF PLANNED PARENTHOOD INSURER C: FEDERATION OF AMERICA, INC. INSURER D 345 WHITNEY AVENUE NEW HAVEN, CT 06511 INSURER E : INSURER F: **REVISION NUMBER:** NYC-004976174-03 CERTIFICATE NUMBER: COVERAGES 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. POLICY EFF | POLICY EXP

| LTR | TYPE OF INSURANCE | INSR WV | POLICY N | UMBER | (MM/DD/YYYY) | (MM/DD/YYYY) | LiMit | 3 |
|-----|--|---------|----------------|-------|--------------|--------------|---|-----------|
| LTR | GENERAL UABILITY | THIS WY | | | | | EACH OCCURRENCE | \$ |
| | | | | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) | s |
| | COMMERCIAL GENERAL LIABILITY | | | | | | MED EXP (Any one person) | \$ |
| | CLAIMS-MADE OCCUR | | | | | | PERSONAL & ADV INJURY | \$ |
| | | | | | | | GENERAL AGGREGATE | \$ |
| | OCHI ACCRECATE LIMIT ADDI IEC DED | | | | | | PRODUCTS - COMP/OP AGG | \$ |
| | GEN'L AGGREGATE LIMIT APPLIES PER: | | | | | | | \$ |
| | AUTOMOBILE LIABILITY | | | | | | COMBINED SINGLE LIMIT (Ea accident) | \$ |
| | ANY AUTO | | | | | | BODILY INJURY (Per person) | \$ |
| | ALL OWNED AUTOS | | | | | | BODILY INJURY (Per accident) | \$ |
| | SCHEDULED AUTOS HIRED AUTOS | | | | | | PROPERTY DAMAGE (Per accident) | \$ |
| | NON-OWNED AUTOS | | | | | | 91.8 B | \$ |
| | UMBRELLA LIAB OCCUR | + | | | | | EACHOCCURRENCE | \$ |
| - 0 | EXCESS LIAB CLAIMS-MADE | | | | | | AGGREGATE | s |
| | Top and the | 1 | | | | | \$1.00 m | \$. |
| | DEDUCTIBLE | | | | | | 1 0 | s |
| | RETENTION \$ WORKERS COMPENSATION | | | | | | WC STATU- OTH- | |
| | AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE | 1 1 | | | | | | S |
| | OFFICER/MEMBER EXCLUDED? (Mandatory in NH) | N/A | | | | | E.L. DISEASE - EA EMPLOYEE | -51 |
| | If yes, describe under DESCRIPTION OF OPERATIONS below | | | | | | ELEDISEASE - POLICY LIMIT | s |
| | DESCRIPTION OF GPERATIONS DOWN | | 1 | | | | - O- | |
| A | ALL RISK PROPERTY | | RMP 2071008541 | | 01/01/2011 | 01/01/2012 | LIMIT | 5,000,000 |
| - | | | | | - 11 | e required) | | |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 181, Additional Remarks Schedule, if more space is required)

RE: 111 POINT STREET, PROVIDENCE, RI 02903

CERTIFICATE HOLDER

CANCELLATION

| PLANNED PARENTHOOD OF SOUTHERN |
|--------------------------------|
| NEW ENGLAND, INC. |
| 345 WHITNEY AVENUE |

NEW HAVEN, CT 06511

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.

Christian Victorino Christian Victorius

| DU no | CORD, CERTIFIC CER (860) 224-2413 Aquist Insurance Associa | | THIS CERTI | FICATE IS ISSU CONFERS NO | JED AS A MATTE D RIGHTS UPON TE DOES NOT A | R OF INFORMATION THE CERTIFICATE AMEND, EXTEND OR POLICIES BELOW. | | | |
|----------|--|--|-------------------------|--|--|--|--|--|--|
| P.0 | Lexington Street Box 368 | 250 | | INSURERS AFFORDING COVERAGE | | | | | |
| | DIICUIII | 052- | INSURER & WOT | kers Compe | nsation Trst | AND THE STREET, STREET | | | |
| NSURI | nned Parenthood of Sout | nern | INSURER B: | | | | | | |
| | England, Inc. | | INSURER C: | AND THE RESIDENCE OF THE PROPERTY OF THE PROPE | | | | | |
| | Whitney Ave | | INSURER D | A CONTRACTOR OF SHIP | CONTRACTOR OF THE CONTRACTOR | and the state of t | | | |
| | Haven CT 06 | 511- | INSURER E | White a said | | Transcription of the second | | | |
| THE | ERAGES POLICIES OF INSURANCE LISTED BELOV UIREMENT, TERM OR CONDITION OF AN INSURANCE AFFORDED BY THE POLI REGATE LIMITS SHOWN MAY HAVE BEE | CIES DESCRIBED HEREIN IS S | UBJECT TO ALL THE | TERMS, EXCLUS | SIONS AND CONDITI | D. NOTWITHSTANDING ANY ISSUED OR MAY PERTAIN, ONS OF SUCH POLICIES. | | | |
| NSR A | DD'L DE MENDANCE | POLICY NUMBER | POLICY EFFECTIVE | POLICY EXPIRATION DATE (MM/DD/YY) | 4 | LIMITS | | | |
| LTR IN | GENERAL LIABILITY | - POLICY HOMBER | 11 | 11 | EACH OCCURRENCE | \$ | | | |
| | COMMERCIAL GENERAL LIABILITY | | | | DAMAGE TO RENTED PREMISES (Ea occurren | ce) S | | | |
| | CLAIMS MADE OCCUR | | 11 | / / | MED EXP (Any one person | man to the same of | | | |
| | | | 200 gran | | PERSONAL & ADV INJU | March 1991 American | | | |
| | | | // | // | GENERAL AGGREGATE | the second secon | | | |
| | GEN'L AGGREGATE LIMIT APPLIES PER: | | | , , | PRODUCTS - COMP/OP | AGG S | | | |
| \dashv | POLICY PRO- JECT LOC | | 11 | 11 | COMBINED SINGLE LIM | ut s | | | |
| | ANY AUTO ALL OWNED AUTOS | | 11 | 11 | BODILY INJURY (Per person) | | | | |
| 0 | SCHEDULED AUTOS HIRED AUTOS | | 11 | 11 | BODILY INJURY (Per accident) | s) | | | |
| | NON-OWNED AUTOS | | 11 | // | PROPERTY BAMAGE (Per accident) | \$ | | | |
| | GARAGE LIABILITY ANY AUTO | | 11 | 11 | AUTO ONLY | AACC S | | | |
| | | | 11 | 11 | EACH OCCURRENCE | s | | | |
| | OCCUR CLAIMS MADE | | | | AGGREGATE | \$ | | | |
| | DEDUCTIBLE | | 11 | 11 | | \$ | | | |
| - | RETENTION S WORKERS COMPENSATION AND | WCP394 | 01/01/2011 | 01/01/2012 | X WC STATU- | OTH- ER | | | |
| A | EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE | | | | E L EACH ACCIDENT | \$ 2,500,000 | | | |
| | OFFICER/MEMBER EXCLUDED? | | 11 | // | E L DISEASE - EA EMP | | | | |
| | If yes, describe under SPECIAL PROVISIONS below | | TO HOUSE OF STREET | , , | E.L. DISEASE - POLICY | LIMIT IS 2/300/00 | | | |
| | OTHER | | 1 / / | 11 | | | | | |
| | | | 1 ', ', | 11 | | | | | |
| | | TOTAL MELONS ADDED BY ENDORSE | MENT/SPECIAL PROVISIO | INS | ************************************** | of the Philosophic Contracts of the Contract of the | | | |
| DESC | RIPTION OF OPERATIONS/LOCATIONS/VEHICL | ES/EXCLUSIONS ADDED BY ENDORSE | MENTIS ESIZETION | | | | | | |
| | | The second secon | CANCELLAT | ION | | | | | |
| CER | TIFICATE HOLDER) - | () - | SHOULD ANY EXPIRATION D | OF THE ABOVE D NATE THEREOF, THE WRITTEN NOTICE TO | HE ISSUING INSURER THE CERTIFICATE HOL | SE CANCELLED BEFORE THE WILL ENDEAVOR TO MAIL DER NAMED TO THE LEFT, BUT BILITY OF ANY KIND UPON THE | | | |
| | Planned Parenthood on New England, Inc. | or southern | | GENTS OR REPRESE | NTATIVES. | | | | |
| | 26 Women's Way | STEED SMITH SHIP THE STEED | AUTHORIZED RE | C C | Jose g. | Toussaint | | | |
| 1 | Meriden | CT 06451-3237 | © ACORD CORPORATION 19 | | | | | | |



DATE (MM/DD/YYYY) 12/23/2010

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).

| | rtificate holder in lieu of such endors | | | CONTA NAME: | CT | | | | |
|--|--|-------------|--|-----------------|--|----------------------------|---|-----------------------------|--|
| PHUL | Marsh USA, Inc. | | | PHONE | | | FAX (A/C, No): | | |
| | 1166 Avenue of the Americas New York, NY 10036 | | | E-MAIL ADDRE | D. EXT): | | (AC, NO): | | |
| | How Young HT Toods | 2.5% | | PRODU | CER | | | | |
| | | | | CUSTO | MERID#: | IIDEDIO ACENT | RDING COVERAGE | NAIC# | |
| more | OFF. | | | Mount | RA: Continental | Casualty Compa | ny | 20443 | |
| INSURED PLANNED PARENTHOOD OF SOUTHERN NEW | | | INSURE | | | | | | |
| | ENGLAND, INC. | | | INSURE | | | | | |
| AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. | | | | INSURE | | | | | |
| | 345 WHITNEY AVENUE | | | INSURE | | | | | |
| | NEW HAVEN, CT 06511 | ** | | INSURE | No. of the last of | | | | |
| 001 | (FDACES CED | TIEICATE | NUMBER: | _ | -004976174-03 | | REVISION NUMBER: | | |
| | IS IN THE SECTION THAT THE DOLLOIS | OF INCLE | DANCE LICTED BELOW HA | VE BEE | N ISSUED TO | THE INSURE | D NAMED ABOVE FOR THE PO | DLICY PERIOD | |
| IN | IIS IS TO CERTIFY THAT THE POLICIES DICATED. NOTWITHSTANDING ANY RE PRITIFICATE MAY BE ISSUED OR MAY ICLUSIONS AND CONDITIONS OF SUCH | PERTAIN | NT, TERM OR CONDITION THE INSURANCE AFFORD | OF AN | THE POLICIE | S DESCRIBE | D HEREIN IS SUBJECT TO ALL | WHICH INIO. | |
| INSR LTR | | ADDL SUBR | POLICY NUMBER | | POLICY EFF | POLICY EXP (MM/DD/YYYY) | LIMITS | | |
| LTR | TYPE OF INSURANCE GENERAL LIABILITY | INSH WVD | POLICI NUMBER | | (AMDED/1111) | | EACH OCCURRENCE \$ | | |
| | COMMERCIAL GENERAL LIABILITY | | | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) \$ | | |
| | | | | | | | MED EXP (Any one person) \$ | | |
| | CLAIMS-MADEOCCUR | | | | | | PERSONAL & ADV INJURY \$ | | |
| | | | | | | | GENERAL AGGREGATE \$ | | |
| | OCANI ACCORDONTE LIMIT ADDI IES DED | | | | | | PRODUCTS - COMP/OP AGG \$ | | |
| | GEN'L AGGREGATE LIMIT APPLIES PER: | | | | | | \$ | | |
| _ | AUTOMOBILE LIABILITY | | | | | | COMBINED SINGLE LIMIT (Ea accident) | | |
| | ANY AUTO | | | | | | BODILY INJURY (Per person) \$ | | |
| | ALL OWNED AUTOS | | | | | | BODILY INJURY (Per accident) \$ | | |
| | SCHEDULED AUTOS | | | | | | PROPERTY DAMAGE S | | |
| | HIRED AUTOS | | | | | | (Per accident) | | |
| | NON-OWNED AUTOS | | | | | | \$ | | |
| | | | | | | | 3-9 9 5 | | |
| | UMBRELLA LIAB OCCUR | | | | | | EACH OCCURRENCE \$ | | |
| | EXCESS LIAB CLAIMS-MADE | 4 | | | | | AGGREGATE \$ | | |
| | DEDUCTIBLE | | | | | | 111 | | |
| | RETENTION \$ | | | | | | WC STATU- OTH- | | |
| | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N | | | | | | | | |
| | ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? | N/A | | | | | E.L. EACH ACCIDENT S | | |
| | (Mandatory in NH) | | | | | | E,L. DISEASE - EA EMPLOYEE \$ | | |
| | If yes, describe under DESCRIPTION OF OPERATIONS below | | | | | | E.L. DISEASE - POLICY LIMIT \$ | | |
| A | ALL RISK PROPERTY | | RMP 2071008541 | | 01/01/2011 | 01/01/2012 | LIMIT | 5,000,00 | |
| DES | CRIPTION OF OPERATIONS / LOCATIONS / VEHIC 11 POINT STREET, PROVIDENCE, RI 02903 | LES (Attach | ACORD 101, Additional Remarks | Scheduk | a, if more space l | s required) | | | |
| CEI | RTIFICATE HOLDER | | | CAN | CELLATION | | | | |
| | PLANNED PARENTHOOD OF SOUTHERN | | | THE | EXPIRATION | N DATE TH | ESCRIBED POLICIES BE CANCE EREOF, NOTICE WILL BE I | LLED BEFORE DELIVERED IN | |

© 1988-2009 ACORD CORPORATION. All rights reserved.

Christian Videnin

AUTHORIZED REPRESENTATIVE

of Marsh USA Inc.

Christian Victorino

NEW ENGLAND, INC. 345 WHITNEY AVENUE

NEW HAVEN, CT 06511

Department of Public Safety Division of Fire, Emergency & Building Services Office of State Fire Marshal



STATE OF CONNECTICUT

| On (date) March 12, 2010, the (town/City) Meriden Office of the Fire Marshal |
|--|
| Conducted an inspection of (name of facility) Planned Parenthood of CT, |
| Located at (address) 26 Women's Wayin the |
| City/Town of to determine the degree of compliance with the |
| Fire safety requirements of Connecticut General Statues Chapter 541 as authorized by |
| Section 29-305 of the statutes. This facility was evaluated as a (new/existing) existing |
| (occupancy classification) Healthcare Clinic as classified |
| by the CONNECTICUT FIRE SAFETY CODE. As a result of this inspection, the following |
| conditions were found. |
| At the time of inspection, no code violations were identified. Certificate of approval recommended II. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. Certificate of approval recommended. III. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. Certificate of approval not recommended. IV. Based on the extreme hazard to public safety discovered at the time of this inspection, this office is currently seeking an injunction from the court through our Town/City Attorney for the purpose of closing or restricting usage of this facility by the public. Certificate of approval not recommended. |
| John Yacovino, Deputy Fire Marshal City or Town Meriden |

| **** | ********* | ************************************** | ******* | | | | |
|-------------------|--|---|--|--|--|--|--|
| | CHECK # | AMOUNT \$ | | | | | |
| | DATE RECEIVED | | | | | | |
| **** | ******** | ********* | ****** | | | | |
| | | | | | | | |
| √ ₁₄ . | Affidavit of Owner: I attest that the information provide in the information submitted will be | ed within this application is true and e reported to the Department as requ | accurate and that any changes ired by law. | | | | |
| | Signature Jahra | Jan 31, 2011 Date Signed | | | | | |
| | Check one as applicable: | | | | | | |
| | [] Individual/Sole Proprietor [] General/Managing Partner [] President of Corporation [] Secretary of Corporation [] Municipal Officer [] Trustee | | RECEIVED 2011 FEB 10 A 11: 15 SPECIAL STREET OF PUBLIC HEALTH SYSTEMS ALL STREET HEALTH SYSTEM | | | | |
| | State of Connecticut |) | 0 | | | | |
| | County of New Haven | _) ss_ Jansary 31 | 20_// | | | | |
| | County of New Have) ss January 31 20 // Personally appeared before me the above named Jody Tabar and made oath to the truth of the statements contained in his/her answers to the foregoing questions. | | | | | | |
| | | Notary Public Justice of the Peace Town Clerk Commissioner of the Super | [] [] rior Court [] | | | | |
| | My Commission Expires: (If Notary Public) My Comm | nission Expires Dec 31, 2011 | | | | | |



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: Planned Parenthood
Facility "d/b/a" (doing business as) Name 1. Telephone 203-238-0542 Check the appropriate box/boxes describing the services to be provided by the clinic: 2. Family Planning
Abortion Procedures [] Primary Care [] Well Child Clinic [] Dental Tasha Blanco - Danglas

Administrator (Your name needs to appear as it is shown on your Professional License). 3. Les Silberman, MD 4. Dental Director (if applicable) Medical Director (Your name needs to appear as it is shown on your Professional License). Hours of Operation: $M = 9^{30} - 4^{15}$, T = 11a - 7p, $W = 8^{30} - 4^{15}$, Th = 11a - 7p, $F = 8^{30} - 4^{15}$ 5. 6 Please provide a list of services that will be provided. 7. On initial application only, submit a copy of the approval from the Office of Health Care Access to establish the clinic. Note: only those clinics which intend to provide primary care services are required to submit OHCA approval.

Herra Slane - 2 31 11
Signature of Administrator Dry Ras Date Signed



434 West 33rd Street, New York, NY 10001 Phone 212.541.7800 · Fax 212.245.1845 www.plannedparenthood.org

July 7, 2011

Amelia Renkert-Thomas, Board Chair Judy Tabar, President/CEO Planned Parenthood of Southern New England, Inc. 345 Whitney Ave. New Haven, CT 06511

Dear Amelia and Judy:

At its June 18, 2011 meeting, the Board of Directors of Planned Parenthood Federation of America, Inc. accepted the recommendation of the Affiliate Development and Accreditation Committee to grant Planned Parenthood of Southern New England, Inc. fully accredited status.

PPSNE's accreditation certificate, which expires July 2014, will be sent by mall. Your next comprehensive review *must* take place a minimum of three months prior to this certificate's expiration. This is necessary in order to assure that your certificate does not expire before your next accreditation review is completed and approved by the ADA committee.

Congratulations! Please extend the good wishes of the committee to your board and staff.

Sincerely,

Lyn M. Schollett, Chair

Affiliate Development & Accreditation Committee

Kathleen Tait, Secretary
PPFA Board of Directors

cc: Deborah R. McHugh, Senior Director, Accreditation and Evaluation Department Molly Eagan, Vice President, Affiliate Services Division



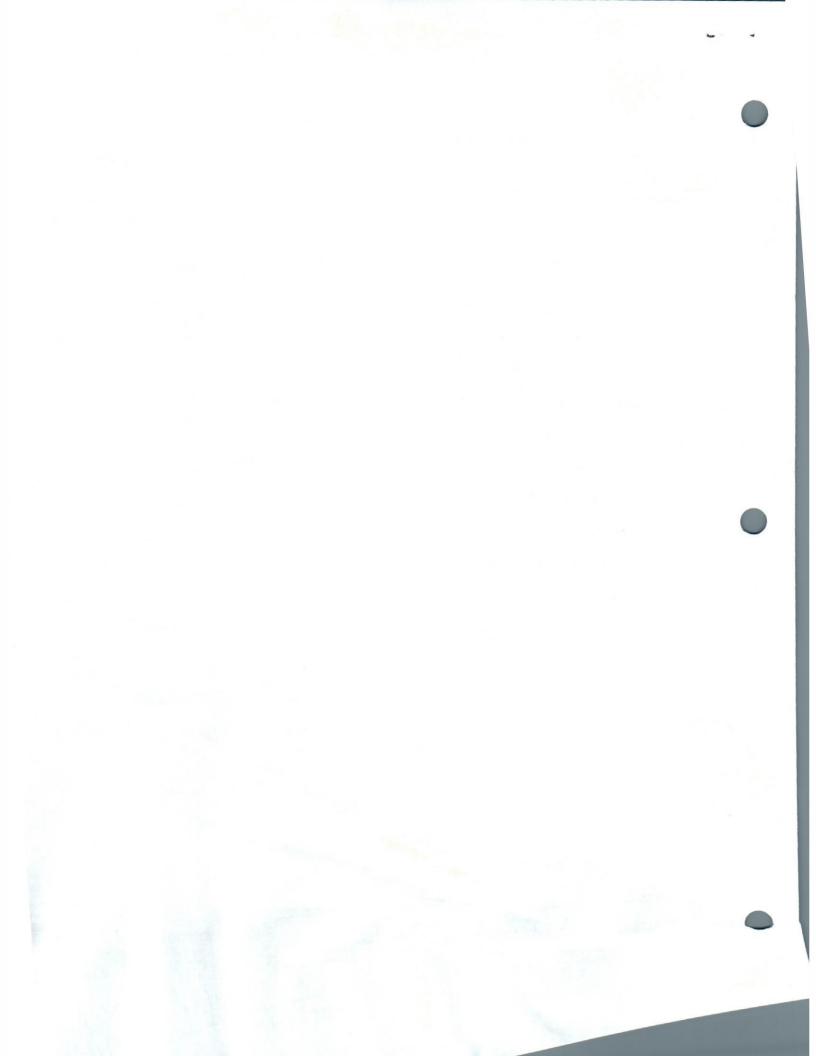
DHSR #13a

STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH SYSTEMS REGULATION

Page 1 of 2

LICENSING INSPECTION REPORT

| | Meriden CT 06457. |
|--------|---|
| Licens | ure Category: Licensed Capacity: Census: |
| | Licensed Capacity: Census: |
| Date(| s) of Onsite Inspection: 1/28/15 |
| | s) Additional Information Obtained: |
| Perso | onnel Contacted: Januar Dobson, Consen manage |
| REVIE | W/FINDINGS/PROCESS (complete all applicable) |
| W | Licensing Inspection: [] Initial Renewal [] Other: |
| [] | Revisit for the Purpose of |
| | See Complaint Investigation # |
| [] | See Reportable Event Investigation # |
| [] | See Certification file. |
| [] | Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were identified at the time of this inspection. See violation letter dated |
| [] | Citation # was issued to this facility as a result of this inspection. |
| W | Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were not identified at the time of this inspection. |
| [] | Citation # was verified as corrected was notified that the licensee was no longer required to post Citation (see narrative). |
| [] | Citation # was not corrected (see narrative). |
| [x] | Narrative Report / Additional Information Attached. |
| f] | Referral(s) to: |
| EPOR | T SUBMITTED BY NEW MSR DATE OF REPORT 1/29/16 |
| | 1.113 |



| FACILITY: | |
|-------------------|------------|
| | Page 2 of |
| DATE(S) of VISIT: | 1 age 2 01 |

OUTPATIENT CLINICS OPERATED BY CORPORATIONS/MUNICIPALITIES LICENSING INSPECTION NARRATIVE REPORT (P.H.C. Section 19-13-D45)

- An unannounced visit was made to the above facility, by a representative of the Division of Health Systems Regulation, for the purpose of conducting a licensing inspection.
- II. An entrance conference was held.
- III. The following was conducted:
 - a. Facility inspection
 - b. Observation of patient care
 - e. Personnel files review
 - d. Quality assurance program (audits) review
 - ce. Fire drill log/disaster plan review
 - f. New or revised agency policies and procedures review
 - g. Clinical record review
 - h. In-service training/staff meeting documentation
 - i. CLIA certificate/waiver
- IV. An exit conference was provided.
- V. Violations of the Public Health Code of the State of Connecticut were/were not identified as a result of this inspection.

SIGNATURE:





DHSR

STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH SYSTEMS REGULATION

Page 1 of 2 wehus]

LICENSING INSPECTION REPORT

| ^ | Name and Address of Entity Signature of DHSR Staff |
|-----------|---|
| 1 | anned Parenthand of Marka a. Melimel Rh, MPt Nuise |
| 2 | Woman's Way |
| | iden, CT 06451 |
| A | nsure Category: nily planning clinic Licensed Capacity: 0011 Census: NA medical abortion Licensed Capacity: Census: |
| | e(x) of Onsite Inspection: July 1, 2011 e(s) Additional Information Obtained: |
| Per | connel Contacted: Loren Fields, APRN; Tasha Blanco-Douglas, center |
| | EW/FINDINGS/PROCESS (complete all applicable) manage |
| IXI | Licensing Inspection: [] Initial [X] Renewal [] Other: |
| 11 | Revisit for the Purpose of |
| 11- | See Complaint Investigation # |
| 11 | See Reportable Event Investigation # |
| [] | See Certification file. |
| L1 | Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were identified at the time of this inspection. See violation letter dated |
| 1.1 | Citation # was issued to this facility as a result of this inspection. |
| 181 | Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were not identified at the time of this inspection. |
| [] | Citation # was verified as corrected. was notified that the licensee was no longer required to post Citation (see narrative). |
| 11 | Citation # was not corrected (see narrative). |
| 11 | Narrative Report / Additional Information Attached. |
| 11 | Referral(s) to: |
| REPOR | TSUBMITTED BY Marcha G. Mel el Ch MAPA DATE OF REPORT 07/01/11 |
| 1 | Approval for Issuance of License granted by: Wan to naugen 7-25-11 |

| Planned Parenthood of Southern New England, - mc. | meriden |
|--|--------------------------|
| DATE(\$) OF VISIT: July 1, 2011 | Page 2 of 7 |
| LICENSING INSPECTION NARRATIVE RE | PORT |
| Licensure inspection conducted onsite. An entrance conference was conducted The following was inspected/reviewed: facility inspection, including patient observation personnel files quality assurance/clinical record review audit fire drill log/disaster plan agency policies and procedures clinical record review | |
| | |
| ✓ OSHA/infection control policies/procedures ✓ review of bylaws, including organizational chart | |
| An exit conference was held. I olations of the Public Health Coo State of Connecticut were no | de of the tidentified |

inspection.

SIGNATURE Marsha J. Mehmel, Ru, MPA Nune Consultant

DHSR

STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH DIVISION OF HEALTH SYSTEMS REGULATION

Page I of 2

LICENSING INSPECTION REPORT

| | Name and Address of Entity Signature of DHSR Staff | |
|-------|---|-------------|
| Pla | anned Parenthand of Marka a. Meline Rh, MPA | Nucle |
| | Southern New England Inc. | consultan |
| 20 | e Woman's Way | |
| me | riden, CT 0645 | |
| A | nsure Category: The planning Clinic Licensed Capacity: 0011 Census: Licensed Capacity: Census: | |
| Pat | | |
| | en of Onsite Inspection: July 1, 2011 | |
| | e(s) Additional Information Obtained: | |
| Pers | sonnel Contacted: Loren Fields, APRN; Taska Blanco-Dougle | rs, center |
| | EW/FINDINGS/PROCESS (complete all applicable) | manage |
| | Licensing Inspection: [] Initial [X] Renewal [] Other: | , |
| ıχı | | |
| 11 | Revisit for the Purpose of | · |
| [] - | See Complaint Investigation # | |
| () | See Reportable Event Investigation # | |
| () | See Certification file. | |
| [] | Violations of the Public Health Code of the State of Connecticut and/or Regulations of State Agencies were identified at the time of this inspection. See violation letter dated | Connecticut |
| ۱. ۱ | Citation# was issued to this facility as a result of this inspection. | |
| 181 | Violations of the Public Health Code of the State of Connecticut and/or Regulations of State Agencies were not identified at the time of this inspection. | Connecticut |
| 1 | Citation # was verified as corrected. that the licensee was no longer required to post Citation (see narrative). | was notifi∝ |
| [] | Citation # was not corrected (see narrative). | 7 |
| 1 1 | Narrative Report / Additional Information Attached. | |
| 11 | Referral(s) to: | |
| REPOI | RT SUBMITTED BY Marcha G. Melinel Rn. M. PA DATE OF REPORT | 07/01/11 |
| 1 1 | Approval for Issuance of License granted by: Logn Dnguyen | 7-11-1 |
| | Supervisor / Title | Date |

