Department of Public Health

LICENSE

License No. 0026

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, Inc. 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 263 Main Street Suite 203 Old Saybrook CT 06475-2326

This license expires March 31, 2018 and may be revoked for cause at any time.

Dated at Hartford, Connecticut, April 1, 2014. RENEWAL.



Jewel Mullen, MD, MPH, MPA

Jawel Mullen M.

Commissioner

Department of Public Health LICENSE

License No. 0026

Outpatient Clinic

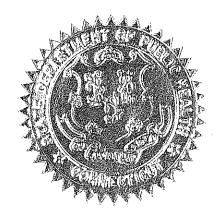
In accordance with the provisions of the General Statutes of Connecticut Section 19a-493: Connecticut Public Health Code, Section 19-13-D54:

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

Planned Parenthood Of Conn., Inc.-Old Saybrook is located at 263 Main Street, Old Saybrook, CT 06475.

This license expires March 31, 2014 and may be revoked for cause at any time.

Dated at Hartford, Connecticut, April 1, 2010. RENEWAL.



J Robert Halvin MD, MPH, MBA



[] INITIAL

STATE OF CONNECTICUT

Page 1 of 4

DEPARTMENT OF PUBLIC HEALTH FACILITY LICENSE & INVESTIGATIONS SECTION

LICENSURE APPLICATION

RENEWAL [] CHANGE OF OWNERSHIP

| NOTICE: Any nursing home licensee, owner or officer, including, |
|--|
| but not limited to, a director, trustee, limited partner, managing |
| partner, general partner or any person having at least 10 per cent |
| (10%) ownership interest, and any administrator, assistant |
| administrator, medical director, director of nursing or assistant |

director of nursing, may be subject to criminal liability, in addition to civil and administrative sanctions under federal and state law, for the abuse or neglect of a resident of the nursing home perpetrated by an employee of the nursing home.

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

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):

| [] General Hospital [] Outpatient Surgical Facility [] Home Health Care Agency [] Residential Care Home [] Homemaker-Home Health Aide Agency [] Rest Home with Nursing Supervision [] Hospice [] In-Patient Hospice United the Nursing Supervision [] In-Patient Hospice United the Nursing Supervision [] Well Child Clinic United the Nursing Supervision [] Well Child Clinic United the Nursing Supervision [] Well Child Clinic United the Nursing Supervision [] Mental Health Day Treatment [] Mental Health Day Treatment [] Mental Health Community Residence [] Mental Health Residential Living | | Home Health Care Agency Homemaker-Home Health Aide Agency Hospice Hospital for Mentally Ill Persons Mental Health Psychiatric OutPat. Mental Health Intermediate Tmt. | | | Residential Care Home Rest Home with Nursing Supervision In-Patient Hospice United Of Public HEALTH Well Child Clinic LITY LICENSING & INVESTIGATION OF MENTAL Health Day Treatment Mental Health Community Residence | n |
|--|--|---|--|--|---|---|
|--|--|---|--|--|---|---|



Phone: (860) 509-7444

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

An Equal Opportunity Employer

| Please | respond to all of the following que | stions: | | | Page 2 o | f 4 |
|--------|---|---------------------|-----------|-----------------|-------------------------|----------------|
| 1. | Planned favent Facility "d/b/a" (doing business as 263 Main St., Suit Business Address | hood of | Sout | hem U | ewEnglo | end The |
| | racinty d/b/a (doing business as | s) Name | , (| ¬ / . | U | /// |
| | 263 Main St., Suit | te 203,0 | olds | aybrody | CT 860- | -388-4459 |
| | Business Address | City | State | Zip Code | Telephone | |
| | | | | | | |
| | Same | City | State | Zip Code | | = |
| | Mailing Address (if applicable) | City | State | Zip Code | | |
| | | | | | | |
| 2. | Bed Capacity Requested (if applic | | | | r multiple levels | of care, |
| | please list the bed capacity for each | in level of care of | enig req | uesteu. | | |
| | Bed | s/ | | | | |
| | | nodialysis Statio | <u>ns</u> | Bassinets (if | applicable) | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| 3. | 06-0263565 | | | | | |
| ٥. | Federal Employer Identification N | Jumber | | | | |
| | | | | | | |
| 4. | Disclose the legal entity which overtity.) | vns/operates the | facility. | (Note: The li | cense will be iss | ued to this |
| | Oliver I Pagartla | 140 | ,, | Non | En land | 7. |
| | Planned Parenthoo Licensee | od of Sole | MEN | 1/4000 | ngiona | LINC. |
| | | / | , / | | J | |
| | 345 Whitney HV | e, New/ | tave | MCT 66 | | 865-5158 |
| | Business Address | City | State | Zip Code | Telephone | |
| | Same | | | |) IE CETY | 121. |
| | Mailing Address (if applicable) | | | 11 | IAM Da == | -,11 |
| | Wanning Address (if applicable) | | | | C 2411 0 0 50 | 134 ; L |
| 5. | Is the above named legal entity a | (please check the | e box wł | nich applies): | üε P¥ _{OHO} | is a big |
| | [] Individual/Sole proprietor | | r 11 | Municipality | | |
| | General Partnership | | | Trust | | |
| | Limited Partnership | | | Profit Corporat | tion | |
| | [] Limited Liability Company | | | | | |
| | Other: | | | | | |
| | Non-profit Corporation | | | | | |
| 6. | Is the above named entity authori | zed by the Office | e of the | Secretary of St | ate to transact by | usiness in the |
| 0. | State of Connecticut and consider | red in Good Star | nding? | YES [] | NO | |
| | | | | | | |

| 7. | - | | e the name, business address and telephone number of the Agent for Service for the |
|-----|-----------------|--|--|
| Š | Name | Tab | or, Pres. + CEO, 345 Whitney Ave., New Haven CTO65 Address Telephone 203-865-515-8 |
| 8. | | | anizational chart which reflects the current ownership structure of the licensee and the ationship with the facility/agency. |
| 9. | | | e specific question that reflects the ownership structure of the licensee. The Licensee is ty which will be issued the license to operate. |
| | A. | | Licensee is a general partnership, limited partnership or limited liability company, ete Form 1 (attached). |
| | B. | If the l | 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. | Licens | Licensee is a <u>corporation</u> (profit or non-profit), complete Form 3 (attached) for the see. Complete a separate Form 3 for each additional corporate entity having 10% or rownership interest in the Licensee. |
| | | i. ii. | 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. | Inforr accep | nation F ted.). P | ent copy of the facility's Certificate of malpractice and public liability insurance. (Note: Pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be lease note that All Behavioral Health levels of care, except hospitals, and RCH facilities om the malpractice requirement. |
| 11. | | a certing Section a certing of the a Certing a | ificate of self-insurance issued by a worker's compensation commissioner pursuant to an 31-284 of the Conn. General Statutes; or ificate of compliance issued by the Insurance Commissioner pursuant to Section 31-286. Conn. General Statutes; or tificate of Insurance issued by any stock or mutual insurance company or mutual insurance issued to write worker's compensation insurance in this state. (Note: |
| 12. | Own | Inforr be acc | mation pages and Insurance Binders are unacceptable. Only Certificates of Insurance will cepted.) f Real Property |
| | Name Busin | e Say ness Ado | therny Rd., Old Saybrook, CT 66475 860-388-929 dress City State Zip Code Telephone |

FLIS LICAPP -001 Rev. 8/13

Planned Parenthood of Southern New England ORGANIZATION CHART

2014

BOARD OF TRUSTEES

(Please attach a list of the board of Trustees)

Planned Parenthood of Southern New England

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Page 2, Line 4 of the renewal application (LICENSEE)

Planned Parenthood of Southern New England

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Page 1, Line 1 of the renewal application (D/B/A)

Planned Parenthood of Southern New England Board of Directors 2013-2014

Officers:

Amelia Renkert-Thomas, Chair
Simone Joyaux, Vice Chair
Sandra Arnold, Secretary
Siw de Gysser, Treasurer
Leigh Bonney, Assistant Treasurer

Board of Directors:

Natalie Adsuar, M.D.

Adriana Arreola-Joseph

Erica Buchsbaum

Gayle Capozzalo

Karen Dubols-Walton

Sue Hessel

Susann Mark

Nadesha Mijoba

Donna Moffly

John R. Morton, M.D.

Susan Ross

Fahd Vahidy

Mary Kay Woods



Attachment 3

FACILITY LICENSING & INVESTIGATIONS SECTIO.

DEPARTMENT OF PUBLIC HEALTH FACILITY LICENSING & INVESTIGATIONS SECTION

FORM 3 FACILITY/AGENCY NAME: Planned Parent hood of Southern 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. ☐ Licensee See attached
☐ Real Property Owner This information is for: Name: 1. 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:

| 4 | CORD CER | ΓIF | IC | ATE OF LIA | BILIT | YIN | SURA | NCE | | (KW/DD/YYY) 1/2013 |
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| B | his certificate is issued as a ertificate does not affirmat elow. This certificate of in epresentative or producer, a | IVEL BURA | Y OF | r negatively amend, Does not constitut | EXTEND | OR ALTI | er the co | VERAGE AFFORDED | BY THE | FOLICIES |
| ŧŧ | APORTANT: If the certificate holder to terms and conditions of the policy ertificate holder in lisu of such ondor | , cer | ain p | olicies may require an er | policy(los) Idarsemoi | must be 16. A slat | endorsed. ement on th | II BUBROGATION IS I is certificate does not | VAIVED confer r | , aubject to lights to the |
| PRO | oucer Izish USA, Ino. | | | | SONTACT | | | | - | |
| 1 | 168 Avenus of the Americas | | | | PHONE (A/G-No-Ex) | l\ 2 | | ĪÊ, 4ο | i. | |
| | low York, NY 10038 Un: healthcara.accountacss@march.com Fax: 212: | 94B-13 | 07 | | E-MAIL ADDRESS: | | | | | |
| | • | V10 10 | ** | | ļ <u>. </u> | | | DING COVERAGE | | NA!O # |
| _ | 210-NIP-CAS-14-15 NEW,C | GLP | <u> </u> | | INSURER A | | лалов Соттралу | | | 38970 |
| P | INSURED PARENTHOOD OF INSURER O : N/A N/A | | | | | | | | | |
| | SOUTHERN NEW ENGLAND, INC. INSURER C: National Union Fire Ins. Co. of Pillsburgh, PA 19445 AN AFFILIATE OF PLANNED PARENTHOOD | | | | | | | | | |
| F | FEDERATION OF AMERICA, INC. | | | | | | | | | |
| | IS WHITNEY AVENUE EW HAVEN, CT 08511 | | | | INSURER E | | | | | |
| - | | YIE! | 1 A Y E | ! ! NUMBER: | INSURER F: | 757581-28 | | REVISION NUMBER: | 1 | |
| | HIS IS TO CERTIFY THAT THE POLICIES | | | | | | | | | ICY PERIOD |
| (N | DICATED. NOTWITHSTANDING ANY R ERYIFICATE MAY BE ISSUED OR MAY KCLUSIONS AND CONDITIONS OF SUCH | EQUIF PERT POLI | ieme Ain, Cies. | nt, term or condition The insurance affordi Limits shown may have | OF ANY CO ED BY THE BEEN REO! | ONTRACT POLICIES UCED BY | OR OTHER (S DESCRIBE(PAID CLAIMS, | OCCUMENT WITH RESPI O HEREIN 18 SUBJECT | ECT TO | WHICH THIS I |
| Non | Type of insurance | ADOL | SURR WVD | POLICY NUMBER | PO (MA) | LICY EFF | POLICY EXP | LIM | 176 | |
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| | X COMMERCIAL GENERAL LIABILITY | | 1 . | | | | | DAMAGE TO RENTED PREMIÉER (FA POOUTERCO) | \$ | 100,000 |
| | CLAIHS-MADE X OCCUR | | | | | | | MED EXP (Any one person) | \$ | 5,000 |
| | X SIR-\$100,000 | | | | | | | PERSONAL & ADV INJURY | \$ | 1,000,000 |
| | | | | | | | | GENERAL AGGREGATE | 3 | 2,000,000 |
| | GENL AGGREGATE LIMIT APPLIES PEH: | 1 | | | | | | PRODUCYS - COMPION AGG | 8 | 2,000,000 |
| | FORTICA TECH X FOC | <u> </u> | | | | | | | \$ | |
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| | UMBRELLA LIAR OCCUR | 1 | | | | - 1 | | EACH OCCURRENCE | 5 | |
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| | DED RETENTIONS WORKERS COMPENSATION | ├ | | | | | | I WO SYAMIA I OTH | \$ | |
| | AND EMPLOYERS' LIABILITY | 1 | | | | | | WO STATU OTH | | |
| | ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDEO? (Mandatory in HH) | HIA | | | | | | EL EACH ACCIDENT | <u> \$</u> | |
| | (Mariostory in MM) If yes, describe under DESCRIPTION OF OPERATIONS below | | | | | į | | E.L DISEASE - EA EMPLOYE | 7 | |
| ^ | MEDICAL PROFESSIONAL | - | | атпара | ٨١٥ | 10014 | nio (Palit | EL DISEASE - POLICY LIMIT | 13 | \$1,000,000 |
| | | ĺ | | 8793288 | 410 | 1/2014 | 1 | PERCLAIM | | |
| | CLAIMS-MADE COVERAGE | ļ. | | Program Retro Date: 11/1/16 | | | | AGGREGATE | | \$3,000,000 |
| Description of operations (Locations (Yexicles (Ausch Acord 101, Additions) Remarks Schedule, if more space is required) | | | | | | | | | | |
| CE | RYIFICATE HOLDER | | | | CANCEL | LATION | · · · · · · · · · · · · · · · · · · · | | | |
| 61 134 34 | Planned Parenthood of Southern New England ATIN: Louis Denegre 345 (Whitney Avenue) SHOULD any of the above described policies be cancelled before the expiration date thereof, notice will be delivered in accordance with the policy provisions. | | | | | | | | | |
| NE | NEW HAVEN, OT 06S11 AUYHORIZED REPRESENTATIVE of March USA Ind. | | | | | | | | | |
| | | | | | Ricki Fitzei | | | Til. Fig. | | |
| | | | | | | @ 19 | 88-2010 AC | ORD CORPORATION. | All rig | its reserved. |
| AGG | AGORD 25 (2010/05) The AGORD name and logo are registered marks of AGORD | | | | | | | | | |



CERTIFICATE OF LIABILITY INSURANCE

DATE (MNODAYYY) 4/11/2013

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 the terms and conditions of the policy | s an AD certain | DITIONAL INSURED, the policies may require an e | policy(ies) must be ndorsement. A sta | endorsed. tement on th | if SUBROGATION IS WAIVE | D, subject to rights to the | |
|---|---------------------------------|---|--|--|---|--------------------------------|--|
| certificate holder in fleu of such endors | sement(s | | GONTACT | | A | | |
| , , | | • | CONTACT Lori Toussaint | | | | |
| Lindquist Insurance Associ | a ces | | PHONE (AIC, No. Ext): (860) 224-2413 FAX (AIC, No.): (860) 225-8917 E-MAIL ADDRESS: Lori. Tousssaint@lindquist-insurance.com | | | | |
| 24 Lexington St | | | | | | | |
| N D AW A'C | AFA | | | | RDÍNG COVERAGE | NAIC # | |
| New Britain CT 06 | 052 | | INSURER A TYUSE | Workers | Compensation | ļ | |
| INSURED | | | INSURER B: | | | | |
| Planned Parenthood Of So. | New Er | ngland, Inc | INSURER C: | | | | |
| 345 Whitney Ave | | • | INSURER D: | | | | |
| | | | INSURER E : | | | | |
| New Haven CT 06 | | | INSURER F : | | | | |
| COVERAGES CER | TIFICAT | ENUMBER:CL1341100 | 728 | | REVISION NUMBER: | | |
| THIS IS TO CERTIFY THAT THE POLICIES INDICATED. NOTWITHSTANDING ANY RECERTIFICATE MAY BE ISSUED OR MAY EXCLUSIONS AND CONDITIONS OF SUCH INSR | QUIREME PERTAIN, POLICIES | INT, TERM OR CONDITION THE INSURANCE AFFORD LIMITS SHOWN MAY HAVI | OF ANY CONTRACT DED BY THE POLICII E BEEN REDUCED BY | FOR OTHER ES DESCRIBE PAID CLAIM | DOCUMENT WITH RESPECT TO AL | O WHICH THIS | |
| LTR TIPE OF INSURANCE | ADOL SUBP | POLICY NUMBER | IMM/OD/YYY1 | IMM/DD/YYYY) | LIMITS | | |
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| COMMERCIAL GENERAL LIABILITY | | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) \$ | | |
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| | | | | | GENERAL AGGREGATE \$ | | |
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| AUTOMOBILE LIABILITY | <u> </u> | | | | COMBINED SINGLE LIMIT (Ea accident) \$ | | |
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| HIRED AUTOS AUTOS | | | | | (Per accident) \$ | | |
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| DED RETENTIONS | | | | | 5 | | |
| A WORKERS COMPENSATION | | | | | X WC STATU- OTH- TORY LIMITS ER | | |
| AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? | | | | | E.L. EACH ACCIDENT \$ | 2,500,000 | |
| I (Mandatory in NH) | N/A | WCP39420 | 1/1/2013 | 3 1/1/2014 | E.L. DISEASE - EA EMPLOYEE \$ | 2,500,000 | |
| If yes, describe under DESCRIPTION OF OPERATIONS below | | | | | | | |
| DESCRIPTION OF OPERATIONS BRIDW | | | | | EL. DISEASE - POLICY LIMIT \$ | 2,500,000 | |
| | | | | Į | | 1 | |
| | 1 1 | | - | | | | |
| | | | | . ,,_ | | | |
| DESCRIPTION OF OPERATIONS / LOCAYIONS / VEHI | sles (Alfac | n ACORO 101, Additional Remark | (9 Scheibile, If More space | e is required) | | | |
| CERTIFICATE HOLDER | | | CANCELLATION | | • | | |
| Planned Parenthood of 345 Whitney Ave | South | ern NE | SHOULD ANY OF | YHE ABOVE I N DATE TH | DESCRIBED POLICIES BE CANCE IEREOF, NOTICE WILL BE I CY FROVISIONS. | | |
| New Haven, CT 06511 | | | AUTHORIZEO REPRES | FHTATIVE | | | |
| | | | Lori Toussaint/LJT - Loui Toussaint | | | | |

ACORD 25 (2010/05)

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DEPARTMENT OF PUBLIC HEALTH FACILITY LICENSING & INVESTIGATIONS SECTION

LICENSURE APPLICATION - ADDITIONAL INFORMATION REQUIRED

OUTPATIENT CLINICS, WELL CHILD CLINICS AND FAMILY PLANNING CLINICS

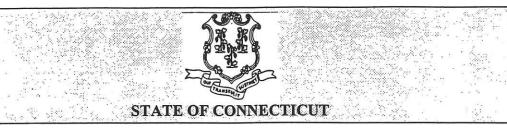
| | respond to all of the following questions: |
|----|---|
| | Planned Parent hood of Southern Hew England, Old Saybrook Facility "d/b/a" (doing business as) Name |
| Ź | DL3 Main St., Suite 203, Old Saybrook, CT 06475 860-388-445 Business Address City State Zip Code Telephone |
| 2. | Check the appropriate box/boxes describing the services to be provided by the clinic: [] Primary Care |
| 3. | 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). |
| 5. | Hours of Operation: Mon. 9-3:30, Tu. 1-7:30, Thurs. 1-7:30, Fri: 10-3:30 |
| 6 | Please provide a list of services that will be provided. JAN 0 6 2013 |
| 7. | Business Fax Number: 860.295-0190 |
| 8. | Business Email Address: beth. burraye appener org |
| 9. | Business Cell Phone Number with Texting capabilities of the Administrator: |
| 18 | In Suran, cm 12/30/13 |
| | Signature of Administrator Date Signed |

| | | | | Page 3 of 4 |
|---|------|-------------------------|-------------------------|--|
| J | 7. | Please <u>Licens</u> | | e the name, business address and telephone number of the Agent for Service for the |
| | | Name | T PE | 1000, PUS. + CEO, 345 WINTHOUGHUE, NOW HOVEN CT OF Telephone (23) 845-5158 |
| | 8. | | | anizational chart which reflects the current ownership structure of the licensee and the tionship with the facility/agency. |
| V | 9. | - | | e specific question that reflects the ownership structure of the licensee. The Licensee is ty which will be issued the license to operate. |
| | | A. | | Licensee is a general partnership, limited partnership or limited liability company, ete Form 1 (attached). |
| | | B. | If the I | Licensee is a <u>trust</u> , complete Form 2 (attached) for the Licensee. |
| | | \wedge | i. | Attach a list including the name, address and telephone number of all trustees. |
| | | (c.) | Licens | Licensee is a <u>corporation</u> (profit or non-profit), complete Form 3 (attached) for the see. Complete a separate Form 3 for each additional corporate entity having 10% or rownership 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. | Inforn accept | nation P ted.). P | ent copy of the facility's Certificate of malpractice and public liability insurance. (Note: lages and Insurance Binders are unacceptable. Only Certificates of Insurance will be lease note that All Behavioral Health levels of care, except hospitals, and RCH facilities om the malpractice requirement. |
| | 11. | | | ace of current compliance with the worker's compensation insurance coverage in the form of one of the following: |
| | | A. | | ficate of self-insurance issued by a worker's compensation commissioner pursuant to an 31-284 of the Conn. General Statutes; or |
| | | В. | a certi | ficate of compliance issued by the Insurance Commissioner pursuant to Section 31-286 Conn. General Statutes; or |
| | | C. | associ <u>Inforn</u> | ificate of Insurance issued by any stock or mutual insurance company or mutual action authorized to write worker's compensation insurance in this state. (Note: nation pages and Insurance Binders are unacceptable. Only Certificates of Insurance will cepted.) |
| | 12. | Owne | rship | f Real Property |
| | 4 | Name DO Busin | ens | Arcs City State Zip Code Telephone |
| | ELIC | LICAPP _ | | U |

FLIS LICAPP -001 Rev. 8/13

| **** | ************* | ************************************** |
|----------------|--|---|
| | CHECK # | AMOUNT \$ |
| | DATE RECEIVED | INITIALS |
| **** | ************* | ************ |
| 13. | Marshal. NOTE: <u>Hospitals</u> must have a completed for each building on the hosp license. Additional forms may be copied | ection Form (attached) must be completed by the Local Fire separate Fire Marshal's Certificate of Inspection bital's campus and each satellite listed on the hospital's dif necessary. Each completed Fire Marshal's ed must have an original signature. (Not applicable for ealth Agencies). |
| 14. | Affidavit of Owner: I attest that the information provided within the information submitted will be reported. | in this application is true and accurate and that any changes ted to the Department as required by law. |
| | Signature Jakan | Date Signed |
| | Check one as applicable: | |
| | Individual/Sole Proprietor General/Managing Partner President of Corporation Secretary of Corporation Municipal Officer Trustee | JAN 13 ZUM |
| | State of Connecticut) | |
| | County of New Haven | ss Jan 2 2014 |
| | Personally appeared before me the above to the truth of the statements contained in | named July Tabal and made oath his/her answers to the foregoing questions. |
| FLIS Rev. 8 | My Commission Expires: (If Notary Public) LICAPP –001 | Sulf Afellum Notary Public [1] Justice of the Peace [1] Town Clerk [1] Commissioner of the Superior Court [1] |

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



| On (date) the Community of Scattley Office of the Fire Marshal conducted an inspection of (name of facility) Plant of Scattley of Scattley New English located at (address) 2/3 Man ST #263 in the City/Town of Scattley Section 29-305 of the statutes. This facility was evaluated as a (newexisting) (occupancy classification) Business as classified by the Connecticut Fire Safety Code. As a result of this inspection, the following conditions were found: 1. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. An acceptable plan of correction was submitted. (See attached information) Certificate of approval plan of correction was submitted. (See attached information) Certificate of approval plan of correction was submitted. (See attached information) Certificate of approval NOT recommended. 11. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. No approval recommended. 12. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. No approval recommended. 13. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. No approval plan of correction was submitted. (See attached information) Certificate of approval NOT recommended. 14. At the time of inspection, conditions were 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, (See attached information) Certificate of approval NOT recommended. | |
|--|--|
| in the City/Town of Classification to determine the degree of compliance with the fire safety requirements of Connecticut General Statutes Chapter 541 as authorized by Section 29-305 of the statutes. This facility was evaluated as a (new/existing) (occupancy classification) Business as classified by the Connecticut Fire Safety Code. As a result of this inspection, the following conditions were found: 1. At the time of inspection, no code violations were identified. Certificate of approval recommended. 11. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. An acceptable plan of correction was submitted. (See attached information) Certificate of approval recommended. 11. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. No approval recommended. 11. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. No approval plan of correction was submitted. (See attached information) Certificate of approval NOT recommended. 12. 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. | |
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| Fire Marshal City or Town: O S S S S S S S S S S S S | |

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 vaccine services
- Transgender services

March 2010

RENEWAL



DEPARTMENT OF PUBLIC HEALTH FACILITY LICENSE & INVESTIGATIONS SECTION

LICENSURE APPLICATION

[] INITIAL

RENEWAL

| NOTE: A separate application must be comp different address. One (1) application may be of care has the same name and the same licens | leted for each licensed level of care which is located at a submitted for multiple levels of care provided each levels each is located at the same address. |
|---|---|
| In accordance with Section 19a-491 and/or Secti is hereby made for a license to operate the follow | on 19a-506 of the Connecticut General Statutes, application ving (please check the appropriate box/boxes that apply): |
| [] Assisted Living Services Agency [] Children's Hospital [] Chronic and Convalescent Nursing Home [] Chronic Disease Hospital [] Family Planning Clinic [] General Hospital [] Home Health Care Agency [] Homemaker-Home Health Aide Agency [] Hospice [] Hospital for Mentally Ill Persons [] Mental Health Psychiatric OutPat. [] Mental Health Intermediate Tmt. [] Substance Abuse & Dependence | [] Infirmary Operated by an Educational Institution [] Maternity Home [] Maternity Hospital [] Outpatient Clinic [] Outpatient Dialysis Unit [] Outpatient Surgical Facility [] Residential Care Home [] Rest Home with Nursing Supervision [] Well Child Clinic [] Mental Health Day Treatment [] Mental Health Community Residence [] Mental Health Residential Living |
| Please respond to all of the following questions: | - Local Of San Control |
| 1. <u>Planned Pareathood of</u> Facility "d/b/a" (doing business as) Nam | Southern New England, Inc. |
| 263 Main St., Suite 203, Business Address Cit | Old Saybrook, CT 06475 860-388-445 |



Same

Mailing Address (if applicable)

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

State Zip Code

City

An Equal Opportunity Employer

| 2. | | ed (if applicable). If submitt acity for each level of care be | | iple levels of care, |
|----|---|--|---|--------------------------|
| | | Beds/ | | |
| | Level of Care | <u>Hemodialysis Station</u> | s Bassinets (if applic | <u>able)</u> |
| | Allen Acceleration and | | | |
| | | - | | |
| | | | | |
| | | | | |
| 3. | 66-0263 Federal Employer Idea | | | |
| 4. | Disclose the legal enti entity.) | ty which owns/operates the f | acility. (Note: The license | will be issued to this |
| | Planned for | weathood of San | athern New Eng | land, Inc. |
| | | | | |
| | 345 Whitney | Ave, New Haven | , CT 06511 21 | 03-865-5158 |
| | Business Address / | City | State Zip Code Tele | ephone |
| | sume | | | |
| | Mailing Address (if ap | plicable) | | |
| 5. | Is the above named le | gal entity a (please check the | box which applies): | |
| | [] Individual/Sole p | roprietor | [] Municipality | |
| | General Partnersl | - | [] Trust | |
| | [] Limited Partnersl | | [] Profit Corporation | i i |
| | [] Limited Liability | Company | | · |
| | [] Other: ✓ Non-profit Corpo | ration | Western the state of the state | |
| | Tron pront corpe | | | |
| 6. | | tity authorized by the Office nd considered in Good Stand | | transact business in the |
| 7. | | me, business address and tele | | |
| | Judy Tabar Pres | +CEO. 345 Whit | near Ave. New Ha | WERCT 06511 |
| | Name | .4CEO, 345 Whit Address | Tel | ephone 2-865-5158 |
| 8. | | nal chart which reflects the c | | |
| • | _ | with the facility/agency. | | |

FACILITY FAX # 860 - 395 - 0190

- 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.
 - 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 Proper | ty | | | | |
|-----|--------------------------|-----------|---------|----------|-----------|---------|
| | Cove In | vestmen | ets, L | L C | | |
| | Name | -115 / | | | | |
| | 9. Bayberry Rd. | Old Sugar | rook, c | T 0647 | 5 860-38 | 28-9296 |
| | Business Address | City / | State | Zip Code | Telephone | |
| | | | | | | |

13. 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).

JAN - 8 2010

| **** | ************ | ************* |
|------|--|---|
| | | FOR OFFICE USE ONLY |
| | CHECK # | AMOUNT \$ |
| | DATE RECEIVED | INITIALS |
| **** | *********** | *********** |
| | | |
| 14. | Affidavit of Owner: I attest that the information provided within in the information submitted will be reported. | this application is true and accurate and that any changes and to the Department as required by law. |
| | Signature Taba | Date Signed |
| | Check one as applicable: | |
| | [] Individual/Sole Proprietor [] General/Managing Partner [] President of Corporation [] Secretary of Corporation [] Municipal Officer [] Trustee | |
| | State of Connecticut) | |
| | County of New Haver | ss December 21 20 09 |
| | Personally appeared before me the above not to the truth of the statements contained in h | amed July Tabar and made oath |
| | My Commission Expires: (If Notary Public) | Sulfatelline Notary Public [1] Justice of the Peace [1] Town Clerk [1] Commissioner of the Superior Court [1] |



Attachment 3

DEPARTMENT OF PUBLIC HEALTH FACILITY LICENSING & INVESTIGATIONS SECTION

FORM 3

FACILITY/AGENCY NAME: Planned Parenthood of Southern New England, Inc.

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 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: |



| | | | | | | DATE (MM/DD/YY) | |
|--|--|---|--------------------------------------|---|-------------------------------------|-----------------------|--|
| L | ACORD. CERTIF | FICATE OF LIABILI | TY INSUI | RANCE | | 1/26/2009 | |
| | UCER | | THIS CERT | FICATE IS ISSU | ED AS A MATTER OF | INFORMATION | |
| WORKERS' COMPENSATION TRUST | | | | ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. | | | |
| Wa | Box 5042 llingford, CT 0649 | 2 | | INSURERS AFFORDING COVERAGE | | | |
| INSU | 03)678-0105 RED Planned Parent | thood of CT, Inc. | INSURER A: WC | rkers' Co | mpensation Tru | st | |
| | | | INSURER B: | | | | |
| | 345 Whitney A | | INSURER C: | | | | |
| | New Haven, CT | 06511 | INSURER D: | | | | |
| | | | INSURER E: | | | | |
| | ERAGES | BELOW HAVE BEEN ISSUED TO THE INS | NIDED NAMED ARO | VE EOD THE DOLLO | Y DEBIOD INDICATED NO | DAIDING | |
| AN MA | IY REQUIREMENT, TERM OR COND IY PERTAIN, THE INSURANCE AFFO | DITION OF ANY CONTRACT OR OTHER I DRDED BY THE POLICIES DESCRIBED HE N MAY HAVE BEEN REDUCED BY PAID CI | DOCUMENT WITH R REIN IS SUBJECT T | ESPECT TO WHIC | H THIS CERTIFICATE MAY | BE ISSUED OR | |
| INSR LTR | TYPE OF INSURANCE | POLICY NUMBER | POLICY EFFECTIVE | POLICY EXPIRATION DATE (MM/DD/YY) | LIMIT | 'S | |
| LIK | GENERAL LIABILITY | | Drite (minipolity) | 51115 (11111) | EACH OCCURRENCE | \$. | |
| Ì | COMMERCIAL GENERAL LIABILITY | | | | FIRE DAMAGE (Any one fire) | \$ | |
| Ì | CLAIMS MADE OCCUP | 110-100 | | | MED EXP (Any one person) | \$. | |
| | | aparta | | | PERSONAL & ADV INJURY | \$ | |
| | | costella | te | | GENERAL AGGREGATE | \$ | |
| | GEN'L AGGREGATE LIMIT APPLIES PER POLICY PRO- | Updated certifica wile be | | a | PRODUCTS - COMP/OP AGG | \$ | |
| | AUTOMOBILE LIABILITY ANY AUTO | certifica wile be forted a soon as received gameory | | | COMBINED SINGLE LIMIT (Ea accident) | \$ | |
| | ALL OWNED AUTOS SCHEDULED AUTOS | Soon as | i | | BODILY INJURY (Per person) | \$ | |
| | HIRED AUTOS NON-OWNED AUTOS | received | | | BODILY INJURY (Per accident) | \$ | |
| | | January | | | PROPERTY DAMAGE (Per accident) | \$ | |
| | GARAGE LIABILITY | | | | AUTO ONLY - EA ACCIDENT | \$ | |
| | ANY AUTO | | | | OTHER THAN EA ACC | \$ | |
| Ì | | | | | AUTO ONLY: AGG | \$. | |
| | EXCESS LIABILITY | | | | EACH OCCURRENCE | \$ | |
| | OCCUR CLAIMS MADE | | | | AGGREGATE | \$ | |
| | | 4- | | | | \$ | |
| | DEDUCTIBLE | * | | .81 | | \$ | |
| | RETENTION \$ | U. | | | | \$ | |
| | WORKERS COMPENSATION AND | | | | X WC STATU- TORY LIMITS ER | | |
| | EMPLOYERS' LIABILITY | WCP 394 | 01/01/09 | 01/01/10 | E.L. EACH ACCIDENT | \$2,500,000 | |
| A | | | | | E.L. DISEASE - EA EMPLOYE | \$2,500,000 | |
| | | | | | E.L. DISEASE - POLICY LIMIT | \$2,500,000 | |
| | OTHER | | | | | e 8 | |
| | | | P Ca if it v | | | | |
| DESC | RIPTION OF OPERATIONS/LOCATIONS/VI | EHICLES/EXCLUSIONS ADDED BY ENDORSEME | NT/SPECIAL PROVISIO | NS | Ni. | | |
| | | JAN - 8 2 | 010 | | g = 8 | | |
| | Na . | LECTION CONTRACTOR | | | | | |
| CER | TIFICATE HOLDER ADI | DITIONAL INSURED; INSURER LETTER: | CANCELLATI | ON | | | |
| | | | SHOULD ANY O | F THE ABOVE DESCR | IBED POLICIES BE CANCELLE | BEFORE THE EXPIRATION | |
| | Planned Paren | thood of CT, Inc. | DATE THEREOF | , THE ISSUING INSUF | RER WILL ENDEAVOR TO MAIL | 10 DAYS WRITTEN | |
| | 263 Main Stree | | NOTICE TO THE | NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL | | | |
| Province Control Contr | | | | IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR | | | |
| | | | | REPRESENTATIVES. | | | |
| | | | AUTHORIZED RE | PRESENTATIVE | 9 11. | - | |
| | 1 | | | fathan | a. exapp | ee | |
| ACC | RD 25-S (7/97) | | | / | ⊕ ACÓŔD C | ORPORATION 1988 | |

| | ACORD CERTIFICA | ATE OF LIABILI | TY INSU | JRANCE | | DATE (MM/DD/YYYY) 12/18/2009 |
|--|--|--|---|--|---|---------------------------------|
| PRO | DDUCER Marsh USA, Inc. 1166 Avenue of the Americas New York, NY 10036 | | ONLY AND HOLDER. TH | CONFERS NO | JED AS A MATTER O RIGHTS UPON TH E DOES NOT AMEN ORDED BY THE POLI | IE CERTIFICATE |
| | | IN | ISURERS AFFOR | RDING COVERA | GE | NAIC# |
| PLANNED PARENTHOOD OF SOUTHERN NEW | | | INSURER A: Markel Insurance Company | | | 38970 |
| ENGLAND, INC. AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. | | IN | INSURER B: National Union Fire Ins. Co. of Pittsburgh, PA | | | 19445 |
| | | 1 HOOD | SURER C: | | | |
| 345 WHITNEY AVENUE NEW HAVEN, CT 06511 | | | SURER D: | | | |
| | | | SURER E: | | | |
| CO | OVERAGES | | | | | |
| | THE POLICIES OF INSURANCE LISTED E NOTWITHSTANDING ANY REQUIREMENT, TE MAY BE ISSUED OR MAY PERTAIN, THE INSI CONDITIONS OF SUCH POLICIES. AGGREGAT | ERM OR CONDITION OF ANY CONT URANCE AFFORDED BY THE POLIC | RACT OR OTHER IES DESCRIBED H | DOCUMENT WITH IEREIN IS SUBJEC | RESPECT TO WHICH T | HIS CERTIFICATE |
| | ADD'L INSRD TYPE OF INSURANCE | POLICY NUMBER | POLICY EFFECTIVE DATE (MM/DD/YYYY) | POLICY EXPIRATION DATE (MM/DD/YYYY) | LIN | мітѕ |
| Α | | 9GLP1007999 | 01/01/2010 | 01/10/2011 | EACH OCCURRENCE DAMAGE TO RENTED | \$ 1,000,000 |
| | X COMMERCIAL GENERAL LIABILITY | | | | PREMISES(Ea occurrence) | \$ 100,000 |

| LIK | INSKU | | | DATE (MM/DD/YYYY) | DATE (MM/DD/YYYY) | | |
|-----|-------|--|-------------------------|-------------------|-------------------|---|--------------|
| Α | | GENERAL LIABILITY | 09GLP1007999 | 01/01/2010 | 01/10/2011 | | \$ 1,000,000 |
| | | X COMMERCIAL GENERAL LIABILITY | 0002. 1001000 | 0 110 1120 10 | 0 11 10/2011 | DAMAGE TO RENTED PREMISES(Ea occurrence) | \$ 100,000 |
| | | CLAIMS MADE X OCCUR | | | | MED EXP (Any one person) | \$ 5,000 |
| | | X SIR: \$100,000 | Mary Santa | | | PERSONAL & ADV INJURY | \$ 1,000,000 |
| | | * | | | | GENERAL AGGREGATE | \$ 2,000,000 |
| - | | GENERAL AGGREGATE LIMIT APPLIES PER PRO- POLICY JECT Y LOC | | | | PRODUCTS - COMP/OP AGG | \$ 2,000,000 |
| _ | - | POLICY JECT X LOC AUTOMOBILE LIABILITY | | | | | |
| | | ANY AUTO | 1431 | | | COMBINED SINGLE LIMIT (Ea accident) | \$ |
| | | ALL OWNED AUTOS | JAN - 8 | 2010 | | BODILY INJURY | \$ |
| | | SCHEDULED AUTOS | 7 | | | (Per person) | Φ |
| | | HIRED AUTOS | - | | | | 6 |
| | | NON-OWNED AUTOS | the state of the paper. | 11 A.S. | | BODILY INJURY (Per accident) | \$ |
| l | | | \$ 10 EVE 100 | 2 11 | | PROPERTY DAMAGE (Per accident) | \$ |
| 1 | | | 2 | | | (Fer accident) | Ψ |
| | | GARAGE LIABILITY | | | | AUTO ONLY - EA ACCIDENT | \$ |
| | | ANY AUTO | | | | OTHER THAN EA ACC | \$ |
| | | | | | | AUTO ONLY: | \$ |
| | | EXCESS / UMBRELLA LIABILITY | | | | EACH OCCURRENCE | \$ |
| | | OCCUR CLAIMS MADE | | | | AGGREGATE | \$ |
| | | | | | 24 | | \$ |
| | | DEDUCTIBLE | | | | | \$ |
| | | RETENTION \$ | | | | | s |
| | | KERS COMPENSATION AND OYERS' LIABILITY | | | | WC STATU- OTH- | |
| | ANY | PROPRIETOR/PARTNER/EXECUTIVE Y / N | | | | E.L. EACH ACCIDENT | \$ |
| | OFFI | CER/MEMBER EXCLUDED? | | | | E.L. DISEASE - EA EMPLOYEE | \$ |
| | (Mand | datory in NH) If yes, describe under | | | | E.L. DISEASE - POLICY LIMIT | |
| | ОТНЕ | | | | | | |
| В | MED | DICAL PROFESSIONAL | 6793286 | 01/01/2010 | 01/01/2011 | PER CLAIM | 1,000,000 |
| 1 | CLA | IMS-MADE COVERAGE | | | | AGGREGATE | 3,000,000 |
| 1 | DDC | GRAM PETRO: 11/01/76 | | | | | |

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENT/SPECIAL PROVISIONS

| CERTI | FICA | CE H | ח וח | FR |
|--------|------|-------|------|----|
| CLIVII | IIVA | _ ,,, | | |

NYC-003599398-19

CANCELLATION

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

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND

UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES. AUTHORIZED REPRESENTATIVE of Marsh USA Inc.

Chris Kakel

Kakel

Planned Parenthood of Southern New England, Inc. Judy Tabar, President and CEO

Board of Directors 2009-2010

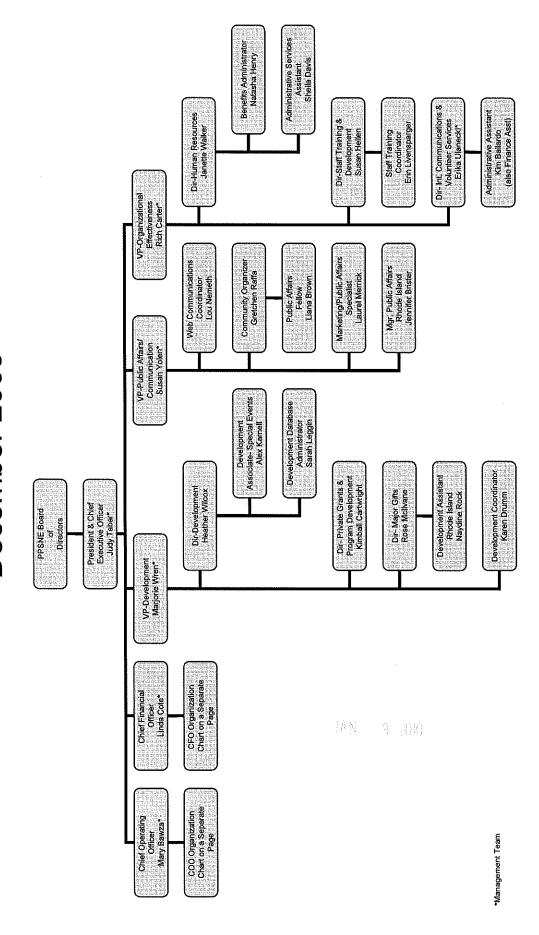
Officers:

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

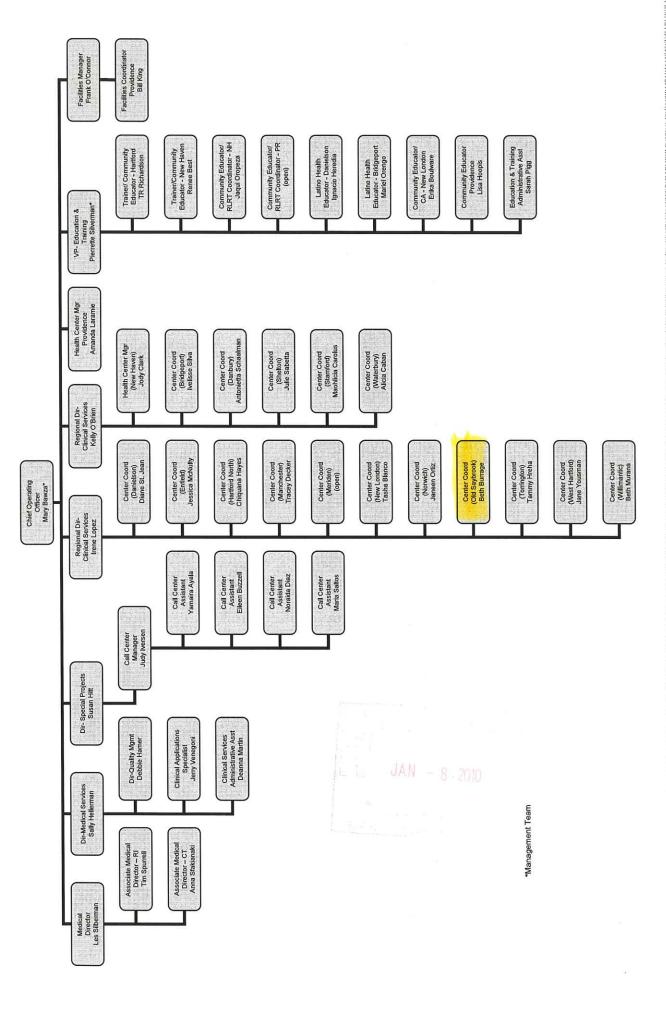
Board of Directors:

Jenny Carrillo, Ph.D.
Bennie Fleming, Ph.D.
Delores Greenlee
Sue Hessel
Nancy Hutson, Ph.D.
Jeannette Ickovics, Ph.D.
Valerie Seiling Jacobs
Rev. Maria LaSala
Donna Moffly
John Morton, M.D.
Shannon Perry
Amelia Renkert-Thomas, J.D.
Richard Sugarman
David Wollin, J.D.
Connie Worthington

Planned Parenthood of Southern New England December 2009



Chief Operating Officer December 2009





STATE OF CONNECTICUT INSPECTION CERTIFICATE

On (date) December 29, 2009, the (Town/City) Old Saybrook Office of the Fire Marshal conducted an inspection of (name of facility) Planned Parenthood located at (address)

263 Main Street in the City/Town of **Old Saybrook** to determine the degree of compliance with the fire safety requirements of Connecticut General Statutes Chapter 541 as authorized by Section 29-305 of the statutes. This facility was designated as a (n) **Existing** (occupancy classification) **Business** as classified by the **CONNECTICUT STATE 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. |
|-----|--|
| п. | At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. An acceptable plan of correction was submitted. (See attached information) Certificate of approval recommended. |
| Ш | 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 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. (See attached information) Certificate of approval NOT recommended. |
| Fir | Pe Marshal Date: January 4, 2010 |

City or Town: Old Saybrook

JAN - 8 2010



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, Old Surproc Facility "d/b/a" (doing business as) Name |
| | 263 Main St., Old Supprook, cT 06475 860-388-4459 Business Address City State Zip Code Telephone |
| 2. | Check the appropriate box/boxes describing the services to be provided by the clinic: |
| | [] Primary Care [⋈ Family Planning [] Well Child Clinic [] Abortion Procedures [] Dental |
| 3. | Reth Burrage, Center Coordinator 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). |
| 5. | Hours of Operation: Mon. 9-5, Tues. 12-8, Thurs. 12-8, Fri. 9-5 |
| 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. |
| | Signature of Administrator 12/18/09 Date Signed |

SERVICES FOR MEN & WOMEN

- STD testing and treatment
- HIV testing and counseling
- Hepatitis B vaccinations
- Tuberculosis testing
- All birth control methods
- Emergency Contraception
- Adoption referral
- HPV vaccinations

- Pregnancy termination including in clinic abortion and abortion
- Annual gynecological exams
 Walk-in pregnancy tests
- Colposcopy, cryosurgery and Leep
 • Mid-life services/harmone
- replacement

 Testing and treatment of vagina
- and urinary tract infections

All services are strictly confidential and affordable. We participate with many insurance plans.