

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0040

Family Planning

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

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 is located at 111 Hazard Avenue Enfield CT 06082-4590

This license expires March 31, 2021 and may be revoked for cause at any time.

Dated at Hartford Connecticut April 1, 2017. RENEWAL



A handwritten signature in cursive script, appearing to read "Raul Pino".

Raul Pino, MD, MPH
Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

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Planned Parenthood of Southern New England is located at 111 Hazard Avenue Enfield CT 06082-4590

This license expires March 31, 2017 and may be revoked for cause at any time.

Dated at Hartford Connecticut April 1, 2014. INITIAL



Jewel Mullen MD

Jewel Mullen, MD, MPH, MPA
Commissioner



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

LICENSURE APPLICATION

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

NOTICE: The State of Connecticut values the quality of care provided to all nursing home residents. Please know that 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 percent (10%) ownership interest in the nursing home or the entity that owns the nursing home, and any administrator, assistant administrator, medical director, director of nursing or assistant director of nursing, may be subject to civil and criminal liability, as well as administrative sanction under applicable federal and state law, for the abuse or neglect of a resident of the nursing home perpetrated by an employee of the nursing home.

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

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

111 Hazard Ave Enfield CT 06082 860 741 8442
 Business Address City State Zip Code Telephone

same as above
 Mailing Address (if applicable) City State Zip Code

2. 060263565
 Federal Employer Identification Number



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

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

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

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

<u>Level of Care</u>	<u>Beds/ Hemodialysis Stations</u>	<u>Bassinets (if applicable)</u>
N/A	_____	_____
_____	_____	_____
_____	_____	_____

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

Planned Parenthood of Southern New England
Licensee

345 Whitney Ave New Haven CT 06511 903 865 5158
Business Address City State Zip Code Telephone

Same as above
Mailing Address (if applicable)

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

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



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

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

LICENSURE APPLICATION - ADDITIONAL INFORMATION REQUIRED

**OUTPATIENT CLINICS, WELL CHILD CLINICS AND
FAMILY PLANNING CLINICS**

Please respond to all of the following questions:

1. Planned Parenthood of Southern New England
Facility "d/b/a" (doing business as) Name
- 111 Hazard Ave Enfield CT 06082 860-741-8442
Business Address City State Zip Code Telephone
2. Is this program a School Based Health Center? Yes No
3. Check the appropriate box/boxes describing the services to be provided by the clinic:
 Primary Care Family Planning
 Well Child Clinic Abortion Procedures
 Dental Mental Health Services

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

4. Jennifer Bouley
Administrator (Your name needs to appear as it is shown on your Professional License).
5. Timothy Spurrell _____
Medical Director Dental Director (if applicable)
(Your name needs to appear as it is shown on your Professional License).
6. Days & Hours of Operation: M 730-330 T 11-7 W 11-7 TH 9-5 F 930-430
You MUST notify this agency when ANY change to the noted day/time changes. We accept email and fax.
7. Please provide a list of services that will be provided. If this is for the addition of services, please also provide the resume of the person(s) who will be providing the services.

**Planned Parenthood of Southern New England
d/b/a Planned Parenthood of Southern New England, Inc.**

Organizational Chart

Board of Directors 2016-2017

OFFICERS:

Simone Joyaux, Chair
Gayle Capozzalo, Vice Chair
Karen Dubois-Walton, Secretary
Leigh Bonney, Treasurer
Frances Padilla, Assistant Treasurer

BOARD OF DIRECTORS:

Bridget Baird
Erica Buchsbaum
Chris Corcoran
Melissa Davis
Holland Dunn
Tekisha Everette
Sue Hessel
Sara Lulo
Susann Mark
Clay Pell
Susan Ross
Nancie Schwarzman
Brett Smiley
Fahd Vahidy



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

Attachment 3

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 Planned Parenthood of Southern New England Inc.
 Next entity on the organizational chart: _____
 Real Property Owner _____

1. Name: N/A - non profit organization without stockholders
 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: _____



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



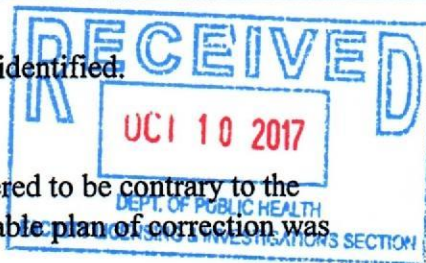
STATE OF CONNECTICUT

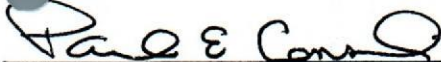
On September 28, 2017, the Thompsonville Fire Department Office of the Fire Marshal conducted an inspection of:
Planned Parenthood
111 HAZARD AVE
ENFIELD, CT 06082

The purpose of this inspection was 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: **BUSINESS OFFICE**

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. An acceptable plan of correction was submitted. (See attached information).
Certificate of Approval recommended.
- III. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. No approval 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 court through our Town Attorney for the purpose of closing or restricting usage of this facility by the public.
Certificate of Approval NOT recommended.




Paul Censki DC

File Number 200168

09/28/2017

Certificate Date



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
12/09/2016

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

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

PRODUCER Marsh USA, Inc. 1166 Avenue of the Americas New York, NY 10036 Attn: healthcare.accounts@marsh.com Fax: 212-946-1307		CONTACT NAME: PHONE (A/C, No, Ext): E-MAIL ADDRESS: FAX (A/C, No):	
109210-NIP-CAS-17-18 NEW,C GL,PL		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 NEW HAVEN, CT 06511		INSURER A: New Hampshire Insurance Company 23841 INSURER B: National Union Fire Ins. Co. of Pittsburgh, PA 19445 INSURER C: INSURER D: INSURER E: INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** NYC-007483661-29 **REVISION NUMBER:** 11

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

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> SIR: \$100,000 GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER:			082695195	01/01/2017	01/01/2018	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 500,000 MED EXP (Any one person) \$ Included PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000 \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	<input type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> DED <input type="checkbox"/> RETENTION \$						<input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE EACH OCCURRENCE \$ AGGREGATE \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below		Y/N	N/A			<input type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
B	MEDICAL PROFESSIONAL CLAIMS-MADE COVERAGE			6793286 Program Retro Date: 11/1/76	01/01/2017	01/01/2018	EACH WRONGFUL ACT \$1,000,000 AGGREGATE \$3,000,000

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

CERTIFICATE HOLDER PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND ATTN: LOUIS DENE GRE 345 WHITNEY AVENUE NEW HAVEN, CT 06511	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE of Marsh USA Inc. Ricki Fitzsimmons
--	--

**Planned Parenthood of Southern New England
d/b/a Planned Parenthood of Southern New England, Inc.**

Organizational Chart

Board of Directors 2016-2017

OFFICERS:

Simone Joyaux, Chair
Gayle Capozzalo, Vice Chair
Karen Dubois-Walton, Secretary
Leigh Bonney, Treasurer
Frances Padilla, Assistant Treasurer

BOARD OF DIRECTORS:

Bridget Baird
Erica Buchsbaum
Chris Corcoran
Melissa Davis
Holland Dunn
Tekisha Everette
Sue Hessel
Sara Lulo
Susann Mark
Clay Pell
Susan Ross
Nancie Schwarzman
Brett Smiley
Fahd Vahidy



CERTIFICATE OF LIABILITY INSURANCE

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

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

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

PRODUCER Marsh USA, Inc. 1166 Avenue of the Americas New York, NY 10036 Attn: healthcare.accounts@marsh.com Fax: 212-948-1307	CONTACT NAME: _____	
	PHONE (A/C, No, Ext): _____	FAX (A/C, No): _____
E-MAIL ADDRESS: _____		
INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A : N/A		N/A
INSURER B : ACE American Insurance Company		22667
INSURER C : N/A		N/A
INSURER D :		
INSURER E :		
INSURER F :		

109210-WC-5-5-16-17 NEW,C WC

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

COVERAGES **CERTIFICATE NUMBER:** NYC-007090697-06 **REVISION NUMBER:** 3

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

INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSD WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER: _____					EACH OCCURRENCE	\$
						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$
						MED EXP (Any one person)	\$
						PERSONAL & ADV INJURY	\$
						GENERAL AGGREGATE	\$
						PRODUCTS - COMP/OP AGG	\$
							\$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON-OWNED AUTOS					COMBINED SINGLE LIMIT (Ea accident)	\$
						BODILY INJURY (Per person)	\$
						BODILY INJURY (Per accident)	\$
						PROPERTY DAMAGE (Per accident)	\$
							\$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$					EACH OCCURRENCE	\$
						AGGREGATE	\$
							\$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N <input checked="" type="checkbox"/> N N/A	RSC C48130549	01/01/2016	01/01/2017	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER	
						E.L. EACH ACCIDENT	\$ 1,000,000
						E.L. DISEASE - EA EMPLOYEE	\$ 1,000,000
						E.L. DISEASE - POLICY LIMIT	\$ 1,000,000

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

EVIDENCE OF COVERAGE

CERTIFICATE HOLDER

PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC.
111 HAZARD AVENUE
NEW HAVEN, CT 06082

CANCELLATION

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

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.

Ricki Fitzsimmons

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
12/09/2016

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

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

PRODUCER Marsh USA, Inc. 1166 Avenue of the Americas New York, NY 10036 Attn: healthcare.accounts@marsh.com Fax: 212-946-1307	CONTACT NAME: _____	
	PHONE (A/C, No, Ext): _____	FAX (A/C, No): _____
E-MAIL ADDRESS: _____		
INSURER(S) AFFORDING COVERAGE		NAIC #
109210-NIP-CAS-17-18 NEW,C PL	INSURER A: N/A	N/A
INSURED PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC., AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. 345 WHITNEY AVENUE NEW HAVEN, CT 06511	INSURER B: National Union Fire Ins. Co. of Pittsburgh, PA	19445
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** NYC-007478047-03 **REVISION NUMBER:** 2

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

INSR LTR	TYPE OF INSURANCE	ADDITIONAL INSURED	SUBROGATION	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER: _____						EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMPIOP AGG \$ \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS						COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTION \$						EACH OCCURRENCE \$ AGGREGATE \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y/N If yes, describe under DESCRIPTION OF OPERATIONS below						PER STATUTE OTHER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
B	MEDICAL PROFESSIONAL CLAIMS-MADE COVERAGE			6793286 Program Retro Date: 11/1/76	01/01/2017	01/01/2018	EACH WRONGFUL ACT \$1,000,000 AGGREGATE \$3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
 EVIDENCE OF COVERAGE FOR HEALTH CENTER

CERTIFICATE HOLDER PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND 111 HAZARD AVENUE ENFIELD, CT 06082	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE of Marsh USA Inc. Ricki Fitzsimmons <i>Ricki Fitzsimmons</i>
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© 1988-2014 ACORD CORPORATION. All rights reserved.

7. Please disclose the name, business address and telephone number of the Agent for Service for the Licensee.
Amanda Skinner 345 Whitney Ave New Haven, CT
Name Address Telephone 803-845-5158

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

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

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

B. If the Licensee is a **trust**, complete Form 2 (attached) for the Licensee.
i. Attach a list including the name, address and telephone number of all trustees.

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

i. If the corporation is incorporated in a state other than Connecticut, please attach a Certificate of Good Standing from the Secretary of State of the state of incorporation.
ii. Attach a list including the name, address and telephone number of all officers and all directors of the corporation.

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

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

- A. a certificate of self-insurance issued by a worker's compensation commissioner pursuant to Section 31-284 of the Conn. General Statutes; or
- B. a certificate of compliance issued by the Insurance Commissioner pursuant to Section 31-286 of the Conn. General Statutes; or
- C. a Certificate of Insurance issued by any stock or mutual insurance company or mutual association authorized to write worker's compensation insurance in this state. (Note: Information pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.)

FOR OFFICE USE ONLY
CHECK # _____ AMOUNT \$ _____
DATE RECEIVED _____ INITIALS _____
RECEIVED
OCT 10 2017
DEPT. OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATION'S SECTION

12. Ownership of Real Property

Name George Colli
Business Address 11 Hazard Avenue City Enfield State CT Zip Code 06082 Telephone 860-253-9603

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

14. Affidavit of Owner:

I attest that the information provided within this application is true and accurate and not made with the intent to mislead a public servant. I attest that such statement is made under oath, that any changes in the information submitted will be reported to the Department as required by law. Any such false statement made therein is punishable by law, as per the CGS 53a-157b.

[Signature]
Signature

9/29/2017
Date Signed

Check one as applicable:

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



State of Connecticut)

County of New Haven) ss 9/29 20 17

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

Sally Hellerman
Notary Public [x]
Justice of the Peace []
Town Clerk []
Commissioner of the Superior Court []

My Commission Expires:
(If Notary Public)

SALLY HELLERMAN
NOTARY PUBLIC
MY COMMISSION EXPIRES DEC. 31, 2021

Jennings, Christine

To: Bouley, Jennifer
Subject: RE: Org. chart, Additional Info. & Board of Directors

All set. Thank you.

From: Bouley, Jennifer [mailto:Jennifer.Bouley@ppsne.org]
Sent: Thursday, October 12, 2017 11:05 AM
To: Jennings, Christine
Subject: Re: Org. chart, Additional Info. & Board of Directors

Hi Christine,

I have talked with Haley, she believes that the additional stuff you need should be fulfilled now with the email she sent you yesterday.

Please let me know if this is no true.

Best,

Jenn



Jennifer Bouley
Center Manager

111 Hazard Avenue | Enfield, CT 06082
P: 860.741.8442 | F: 860.221.3910
Jennifer.Bouley@ppsne.org | www.ppsne.org

Providing Answers. Honoring Choices. Creating Hope.

NOTE: This transmission, and any files that may accompany it, contain information belonging to Planned Parenthood of Southern New England and is considered confidential and/or legally privileged. If you are not the intended recipient, any disclosure, copying, distribution or the taking of any action in reliance on the contents of this transmission is strictly prohibited. If you believe you have received this transmission in error, please contact the sender and permanently delete this e-mail and its attachments from your system immediately.

om: Jennings, Christine <Christine.Jennings@ct.gov>
Sent: Wednesday, October 11, 2017 4:39 PM

To: Bouley, Jennifer

Subject: RE: Org. chart, Additional Info. & Board of Directors

Thank you for the list of Board of Directors. But the org. chart is not what this office is looking for. All we need is the forms that you will find from the Renewal Application. Page 1 line 1, page 2 line 5. List of Board of Directors.

From: Bouley, Jennifer [<mailto:Jennifer.Bouley@ppsne.org>]

Sent: Wednesday, October 11, 2017 2:53 PM

To: Jennings, Christine

Subject: Re: Org. chart, Additional Info. & Board of Directors

The one i submitted is correct. Haley Vincent also sent you the officers and board of directors.



Jennifer Bouley
Center Manager

111 Hazard Avenue | Enfield, CT 06082

P: 860.741.8442 | F: 860.221.3910

Jennifer.Bouley@ppsne.org | www.ppsne.org

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From: Jennings, Christine <Christine.Jennings@ct.gov>

Sent: Wednesday, October 11, 2017 2:47:04 PM

To: Bouley, Jennifer

Subject: RE: Org. chart, Additional Info. & Board of Directors

The org. chart is incorrect, please see attached chart and list of board of directors that was submitted in 2013, did anything change from 2013 & 2015-16?

From: Bouley, Jennifer [<mailto:Jennifer.Bouley@ppsne.org>]

Sent: Wednesday, October 11, 2017 1:26 PM

To: Jennings, Christine

Subject: Re: Org. chart, Additional Info. & Board of Directors

Hi,

Attached are the forms you requested.

Thanks,

Jenn

Jennifer Bouley
Center Manager

111 Hazard Avenue | Enfield, CT 06082
P: 860.741.8442 | F: 860.221.3910
Jennifer.Bouley@ppsne.org | www.ppsne.org

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From: Jennings, Christine <Christine.Jennings@ct.gov>
Sent: Wednesday, October 11, 2017 1:10:40 PM
To: Bouley, Jennifer
Subject: Org. chart, Additional Info. & Board of Directors

Please see 9 of the attached application for the additional information form. Thank you.

Attached are the forms you requested.

Thanks,

Jenn



Jennifer Bouley
Center Manager

111 Hazard Avenue | Enfield, CT 06082
P: 860.741.8442 | F: 860.221.3910
Jennifer.Bouley@ppsne.org | www.ppsne.org

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From: Jennings, Christine <Christine.Jennings@ct.gov>
Sent: Wednesday, October 11, 2017 1:10:40 PM
To: Bouley, Jennifer
Subject: Org. chart, Additional Info. & Board of Directors

Please see 9 of the attached application for the additional Information form. Thank you.

From: Bouley, Jennifer [<mailto:Jennifer.Bouley@ppsne.org>]
Sent: Wednesday, October 11, 2017 2:53 PM
To: Jennings, Christine
Subject: Re: Org. chart, Additional Info. & Board of Directors

The one i submitted is correct. Haley Vincent also sent you the officers and board of directors.



Jennifer Bouley
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From: Jennings, Christine <Christine.Jennings@ct.gov>
Sent: Wednesday, October 11, 2017 2:47:04 PM
To: Bouley, Jennifer
Subject: RE: Org. chart, Additional Info. & Board of Directors

The org. chart is incorrect, please see attached chart and list of board of directors that was submitted in 2013, did anything change from 2013 & 2015-16?

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Sent: Wednesday, October 11, 2017 1:26 PM
To: Jennings, Christine
Subject: Re: Org. chart, Additional Info. & Board of Directors

Hi,

Attached are the forms you requested.

Thanks,

Jenn



Jennifer Bouley
Center Manager

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From: Jennings, Christine <Christine.Jennings@ct.gov>
Sent: Wednesday, October 11, 2017 1:10:40 PM
To: Bouley, Jennifer
Subject: Org. chart, Additional Info. & Board of Directors

Please see 9 of the attached application for the additional Information form. Thank you.

NOV 2013

RENEWAL



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

LICENSURE APPLICATION

INITIAL 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):

- | | |
|--|---|
| <input type="checkbox"/> Assisted Living Services Agency | <input type="checkbox"/> Infirmary Operated by an Educational Institution |
| <input type="checkbox"/> Children's Hospital | <input type="checkbox"/> Maternity Home |
| <input type="checkbox"/> Chronic and Convalescent Nursing Home | <input type="checkbox"/> Maternity Hospital |
| <input type="checkbox"/> Chronic Disease Hospital | <input type="checkbox"/> Outpatient Clinic/Primary Care |
| <input checked="" type="checkbox"/> Family Planning Clinic | <input type="checkbox"/> Outpatient Dialysis Unit |
| <input type="checkbox"/> General Hospital | <input type="checkbox"/> Outpatient Surgical Facility |
| <input type="checkbox"/> Home Health Care Agency | <input type="checkbox"/> Residential Care Home |
| <input type="checkbox"/> Homemaker-Home Health Aide Agency | <input type="checkbox"/> Rest Home with Nursing Supervision |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> In-Patient Hospice Unit |
| <input type="checkbox"/> Hospital for Mentally Ill Persons | <input type="checkbox"/> Well Child Clinic |
| <input type="checkbox"/> Mental Health Psychiatric OutPat. | <input type="checkbox"/> Mental Health Day Treatment |
| <input type="checkbox"/> Mental Health Intermediate Tmt. | <input type="checkbox"/> Mental Health Community Residence |
| <input type="checkbox"/> Substance Abuse & Dependence | <input type="checkbox"/> Mental Health Residential Living |

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 questions:

✓ 1. Planned Parenthood of Southern New England

Facility "d/b/a" (doing business as) Name

111 Hazard Avenue Enfield, Ct 06082

Business Address City State Zip Code Telephone ✓

same

Mailing Address (if applicable) City State Zip Code

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

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

✓ 3. 060263565
Federal Employer Identification Number

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

Planned Parenthood of Southern New England

Licensee
345 Whitney Avenue New Haven, Ct 06511 203.865.5158

Business Address City State Zip Code Telephone

same

Mailing Address (if applicable)

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

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

6. 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? [X] YES [] NO

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

_Judy Tabar 345 Whitney Avenue New Haven, Ct 06511 203.865.5158

- | Name | Address | Telephone |
|------|---------|-----------|
|------|---------|-----------|
8. Attach an organizational chart which reflects the current ownership structure of the licensee and the licensee's relationship with the facility/agency.
9. Respond to the specific question that reflects the ownership structure of the licensee. **The Licensee is the legal entity which will be issued the license to operate.**
- A. If the Licensee is a **general partnership, limited partnership or limited liability company**, complete Form 1 (attached).
- B. If the Licensee is a **trust**, complete Form 2 (attached) for the Licensee.
- i. Attach a list including the name, address and telephone number of all trustees.
- C. If the Licensee is a **corporation (profit or non-profit)**, complete Form 3 (attached) for the Licensee. Complete a separate Form 3 for each additional corporate entity having 10% or greater ownership interest in the Licensee.
- i. If the corporation is incorporated in a state other than Connecticut, please attach a Certificate of Good Standing from the Secretary of State of the state of incorporation.
- ii. Attach a list including the name, address and telephone number of all officers and all directors of the corporation.
10. Attach a current copy of the facility's Certificate of malpractice and public liability insurance. (Note: Information Pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.) Please note that All Behavioral Health levels of care, except hospitals, and RCH facilities are exempt from the malpractice requirement.
11. Attach evidence of current compliance with the worker's compensation insurance coverage requirements in the form of one of the following:
- A. a certificate of self-insurance issued by a worker's compensation commissioner pursuant to Section 31-284 of the Conn. General Statutes; or
- B. a certificate of compliance issued by the Insurance Commissioner pursuant to Section 31-286 of the Conn. General Statutes; or
- C. a Certificate of Insurance issued by any stock or mutual insurance company or mutual association authorized to write worker's compensation insurance in this state. (Note: Information pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.)
12. Ownership of Real Property
_Colli Management LLC 76 Mountain Road Suffield, Ct 06078

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

^

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

Planned Parenthood of Southern New England

^

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 Dubois-Walton

Sue Hessel

Susann Mark

Nadesha Mijoba

Donna Moffly

John R. Morton, M.D.

Susan Ross

Fahd Vahidy

Mary Kay Woods



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
12/31/2013

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

PRODUCER Marsh USA, Inc. 1166 Avenue of the Americas New York, NY 10036 Attn: healthcare.accounts@marsh.com Fax: 212-948-1307		CONTACT NAME: PHONE (A/C No. Ext): FAX (A/C, No): E-MAIL ADDRESS:	
109210-NP-CAS-14-15 NEW, C GLPL		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 NEW HAVEN, CT 06511		INSURER A: Market Insurance Company 38970 INSURER B: N/A N/A INSURER C: National Union Fire Ins. Co. of Pittsburgh, PA 19445 INSURER D: INSURER E: INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** NYC-005767681-26 **REVISION NUMBER:** 11

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

INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSR	INSR	Y/V/D	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR <input checked="" type="checkbox"/> SIR: \$100,000 GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC				3C41034	01/01/2014	01/01/2015	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COM/PROP AGG \$ 2,000,000
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS							COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED RETENTIONS \$							EACH OCCURRENCE \$ AGGREGATE \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory In NH) If yes, describe under DESCRIPTION OF OPERATIONS below			Y/N	N/A			WC STATU-TORY LIMITS OTH-ER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$
C	MEDICAL PROFESSIONAL CLAIMS-MADE COVERAGE				6793286	01/01/2014	01/01/2015	PER CLAIM \$1,000,000 AGGREGATE \$3,000,000 Program Retro Date: 11/1/76

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

CERTIFICATE HOLDER PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND ATTN: LOUIS DENEGRE 345 WHITNEY AVENUE NEW HAVEN, CT 06511	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE of Marsh USA Inc. Ricki Filzsimmons <i>Ricki Filzsimmons</i>
---	---

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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
01/14/2014

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

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

PRODUCER Marsh USA, Inc. 1166 Avenue of the Americas New York, NY 10036 Attn: healthcare.accounts@marsh.com Fax: 212-948-1307		CONTACT NAME: PHONE (A/C, No, Ext): FAX (A/C, No): E-MAIL ADDRESS:	
109210-WC-5-5-14-15 NEW,C WC		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 NEW HAVEN, CT 06511		INSURER A: ACE American Insurance Company 22667 INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** NYC-006791941-01 **REVISION NUMBER:** 1

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

INSR LTR	TYPE OF INSURANCE	ADDL'SUBR/INSR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
	GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC					EACH OCCURRENCE \$ DAMAGE TO RENTED PREMISES (Ea.occurrence) \$ MED EXP (Any one person) \$ PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ \$
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS					COMBINED SINGLE LIMIT (Ea. accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	UMBRELLA LIAB EXCESS LIAB OCCUR CLAIMS-MADE DED RETENTION \$					EACH OCCURRENCE \$ AGGREGATE \$ \$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N N	RSC C47330634	01/01/2014	01/01/2015	<input checked="" type="checkbox"/> WC STATUTORY LIMITS OTH-ER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000

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

CERTIFICATE HOLDER PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC. 76 PALOMBA DRIVE ENFIELD, CT 06082	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE of Marsh USA Inc. Ricki Fitzsimmons <i>Ricki Fitzsimmons</i>
--	---



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

LICENSURE APPLICATION - ADDITIONAL INFORMATION REQUIRED

OUTPATIENT CLINICS, WELL CHILD CLINICS AND
FAMILY PLANNING CLINICS

Please respond to all of the following questions:

- 1. Planned Parenthood of Southern New England
Facility "d/b/a" (doing business as) Name
111 Hazard Avenue, Enfield, Ct 06082 860.741.2197

Business Address City State Zip Code Telephone

- 2. Check the appropriate box/boxes describing the services to be provided by the clinic:
[] Primary Care [X] Family Planning
[] Well Child Clinic [] Abortion Procedures
[] Dental

- 3. Caitlin Murphy
Administrator (Your name needs to appear as it is shown on your Professional License).

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

- 5. Hours of Operation: M 11:00 am - 7:00 pm T 8:30 am - 4:30 pm W 8:30 am - 4:30 pm Th 11:00 am - 7:00 pm F 8:30 am - 4:30 pm

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

- 7. Business Fax Number: 860.741.8442

- 8. Business Email Address: Caitlin.murphy@ppsne.org

- 9. Business Cell Phone Number with Texting capabilities of the Administrator: 203.530.9241

Caitlin Murphy
Signature of Administrator

02/03/2014
Date Signed



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

HEALTH CENTER STAFF – January 21, 2014

	BRIDGEPORT	DANBURY	DANIELSON	ENFIELD	HARTFORD NORTH	MANCHESTER
CENTER MANAGER	Ivelisse Silva	Antonietta Schaalman	Brittney Schultz	Caitlin Murphy	Heather Dellago	Sandy Dowell
CLINICIAN	Laurio Haydu Linda Magee Diana Soto, PD	Jennifer Ryan Joan Wiech, PD	Lindsay Delaire Lisa Marie Griffiths, PD	Chris Bachand Christina Fantoni, PD Amy Konefick, PD	Debbie Hamer	Maria Banevidus Diane Libby-Ramage Kristine Sterling, PD
RN						
LPN					Sursattie Nepal	Bridget Tomczak
CA	Lailsha Ervin (float) Omar Jehaludi Nikole Moya Tenise Paulding, PD Michelle Reid, PD	Anntreen Lamar	Jessa Goldstein Stephanie Nix Sheri Saddlemire	Claudia Valderrama	Natacha Roman Molario Vazquez (float)	Brianne Johnson
ADVANCED CA	Amber Bachman Evelyn Cuevas* Lori Gall Aida Ortega* Karl Peters, PD	Gabriela Ambroso* Jennifer Tomasini	Jacklyn Michalski, PD	Jennifer Bouley Danielle Deschaine	Yolanda Young	Shondra Bochtold Leah Bell Niccolotte Laume Norimar Nieves*
REGIONAL DIRECTOR	Kelly O'Brien	Koly O'Brien	Shira Revzen	Shira Revzen	Shira Revzen	Shira Revzen

	MERIDEN/NEW BRIT	NEW HAVEN	NEW LONDON	NORWICH	OLD SAYBROOK	PROVIDENCE
CENTER MANAGER	Samantha Dobson	Jody Clark	Usa Hodges-Velasquez	Janeen Ortiz*	Beth Burrage	Danna Freedman-Shara
CLINICIAN	Loren Fields Kathy Bryson Jenna LoGiudice, PD	Kirsten Asmus Carrie Ferrigno Janet Gumaer Wei-Ti Chen, PD Constance Chmura, PD Gina Novick, PD Leslie Robinson, PD Margaret Withington, PD	Sarah Whalen Edie Morren-Morrison, PD	Kris Robin Stephanie Malla, PD	Elizabeth Fabrizi	Stacy Ramsey Jessica Wilder Stephanie Avila, PD Melanie Hill, PD Constance Chang, PD Megan Gaynor Charette*, PD
RN		LaToya Ward Erin Paduda Sarah Acker, PD Pamela Lee, PD Sari Gottlieb-Sherman, PD				Paula Golden Paulina Niechodal, PD Amy Gordon, PD
LPN	Dalva Morales*			Elaine Robinson		
CA	Arlinda Carr Casandra Lohr	Hector Cotto Whitney Davis Cholsea Epps Meroy Plant	Tylisha Wrighten	Hannah Carey Stephen Polach Jessica Stofanski		Kayla Murphy Amber Newmann Tara Patterson Pam Shaw Harriet Singer Nindi Tiemo Brianna Jolacoso
ADVANCED CA	Keri Geoghegan Viviana Hernandez* Tina St. Germain Jose Vargas	Victoria Burch Omara de la Cruz* Eshe Hamilton Candice Langloy Esther Pollot* Carmen Trochaz* Nicola Zullo	Bernadette DeShields Damaris Hernandez* Lindsey Jones Veronica Sohn	Donna Bonanno Jossica Davila*	Nicole Corona Susan Schlachter	Antigone Royes Esperanza Santana* Eri Valerio*
REGIONAL DIRECTOR	Kelly O'Brien	Kelly O'Brien	Shira Revzen	Shira Revzen	Kelly O'Brien	Shira Revzen

	STAMFORD	TORRINGTON	WATERBURY	WEST HARTFORD	WILLIMANTIC
CENTER MANAGER	Machilda Carolus**	Tammy Hreha	Alicia Caban*	Jane Youseman	Beth Murana
CLINICIAN	Gannon Ward Inos Riera, PD Susan Ruel, PD	Claudette Baril	Ronnie Dubrowin* Karen Parkhurst, PD	Mark Piarco Rodrigo DePasquale Emily Cota, PD	Jill Cassells
RN	Allison Lomas Michelle Miller, PD Miren Katixa Aboltiz, PD			Kate Siver* Samantha Hyacinth, PD Emily Yeast, PD	
CA	Anabel Moral-Rodriguez Catherine Osorio Sandra Pinto Melina Rankine Yolanda Rosado*	Jennifer Heit Heather Keyes	Michelle Jimenez* Claudia Polanco	Emily Kersey Jolsebel Lopez Morayma Rodriguez	Jillian Librandi Franceska Vega
ADVANCED CA	Mayra Torres* Eynn Jackson, PD Daphne Mondesi**, PD	Jasmine Osorio	Erika Vanamringo Ivelisse Vasquez*	Madeline Alvarez* Mary Cruz* Getzenia Nieves* Jenny Martorell, PD Kaitlin Sohn, PD	Lillian Morales*
REGIONAL DIRECTOR	Kelly O'Brien	Kelly O'Brien	Kelly O'Brien	Shira Revzen	Shira Revzen

*Bilingual English/Spanish **Bilingual English/French PD = Por Dem

Name _____

Business Address _____ City _____ State _____ Zip Code _____ Telephone _____

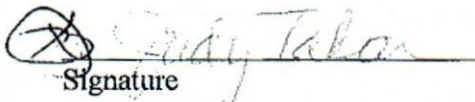
FOR OFFICE USE ONLY

CHECK # _____ AMOUNT \$ _____

DATE RECEIVED _____ INITIALS _____

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

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


Signature

1/30/14
Date Signed

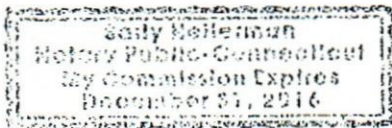
Check one as applicable:

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

State of Connecticut)

County of New Haven) ss January 30, 20 14

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



Sally Mellenum
Notary Public [X]
Justice of the Peace []
Town Clerk []
Commissioner of the Superior Court []

Application For 111 Hazard Ave Planned Permit

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

Please fill out



STATE OF CONNECTICUT

On (date) 2-21-2014, the (Town/City) Thompsonville Office of the Fire Marshal conducted at inspection of (name of facility) PLANNED PERMIT HOLD OF ENFIELD located at (address) 111 HAZARD AVE in the City/Town of ENFIELD, CT to determine the degree of compliance with the fire safety requirements of Connecticut General Statutes 541 as authorized by Section 29-305 of the statutes. This facility was evaluated as a (new/existing) NEW (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. An acceptable plan of correction was submitted. (See attached information) Certificate of approval recommended.
- III. At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. No approved plan of correction was submitted. (See attached information) Certificate of approval NOT recommended.
- IV. Based on the extreme hazard to 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.

[Signature]
Fire Marshal

2-24-2014
Date

City or Town: ENFIELD/Thompsonville

File B3-13

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



Town of Enfield ~ Division of Building Inspection
820 Enfield Street, Enfield, Connecticut 06082
Telephone: (860) 253-6370
www.enfield-ct.gov

CERTIFICATE OF OCCUPANCY

Related Building Permit #: BP57151

C. O. #: CO57545

Building Code Edition: 2011

Date of Issue: 02/24/2014

Property Owner: COLLI MANAGEMENT LLC
76 MOUNTAIN RD
SUFFIELD, CT 06078

Owner Telephone:

Job Location: 111 HAZARD AVE

Parcel ID: 001000010075

Job Name: PPSNE

Portion of structure for which the certificate is issued:
INTERIOR DEMO AND FIT OUT FOR NEW TENANT

Construction Type: V-B

Use Group: BUSINESS

Occupancy: MEDICAL OFFICE

Design Occupant Load: 35

Automatic Sprinkler Provided: NO

Sprinkler System Required: NO

Special stipulations and conditions of the building permit:

NONE

The described portion of the structure has been inspected for compliance with the requirements of the Connecticut State Building Code for the occupancy and division of occupancy and the use for which the proposed occupancy is classified.

Building Official's Signature