#### **Department of Public Health**

#### LICENSE

License No. 0025

#### **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 Connecticut Inc.-Torrington is hereby licensed to maintain and operate a Family Planning.

Planned Parenthood of Connecticut Inc.-Torrington is located at 249 Winsted Road Torrington CT 06790

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 MB

Commissioner

# Department of Public Health LICENSE

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& Robert Holin MD, MPH, MBA

#### **Department of Public Health**

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Dated at Hartford, Connecticut, April 1, 2006. RENEWAL.



I Robert Delvin M.D., M.R.K.



#### STATE OF CONNECTICUT

#### DEPARTMENT OF PUBLIC HEALTH FACILITY LICENSE & INVESTIGATIONS SECTION

#### LICENSURE APPLICATION

| [ ] INITIAL      | X RENEWAL          | [ ] CHANGE OF OWNERSHIP                 |
|------------------|--------------------|---|
| NOTICE: Any      | nursing home       | licensee, owner or officer, including,  |
| but not limited  | to, a director, tr | ustee, limited partner, managing        |
| partner, genera  | l partner or any   | person having at least 10 per cent      |
| (10%) ownershi   | p interest, and    | any administrator, assistant            |
| administrator, r | nedical director   | , director of nursing or assistant      |
| director of nurs | ing, may be sub    | ject to criminal liability, in addition |
| to civil and adm | inistrative sanc   | tions under federal and state law, for  |
| the abuse or neg | glect of a resider | nt of the nursing home perpetrated      |
| by an employee   | of the nursing l   | iome.                                   |
|                  |                    |   |

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):

| []  | Assisted Living Services Agency       | [ | ] | Infirmary Operated by an Educational Institution   |
|-----|---------------------------------------|---|---|--|
| [ ] | Children's Hospital                   | ] | ] | Maternity Home   |
| []  | Chronic and Convalescent Nursing Home | [ | ] | Maternity Hospital   |
| [ ] | Chronic Disease Hospital              | ] | ] | Maternity Hospital Outpatient Clinic/Primary Care Outpatient Dialysis Unit                 |
| X   | Family Planning Clinic                | [ | ] | Outpatient Dialysis Unit   |
| [ ] | General Hospital                      | [ | ] | Outpatient Dialysis Unit Outpatient Surgical Facility  AN 09 2019  Pacidontial Core Harres |
| [ ] | Home Health Care Agency               | [ | ] | Residential Care Home  |
| [ ] | Homemaker-Home Health Aide Agency     | [ | ] | Rest Home with Nursing Supervision   |
| [ ] | Hospice                               | [ | ] | In-Patient Hospice Unit  |
| [ ] | Hospital for Mentally Ill Persons     | [ | ] | Well Child Clinic  |
| [ ] | Mental Health Psychiatric OutPat.     | [ | ] | Mental Health Day Treatment  |
| [ ] | Mental Health Intermediate Tmt.       | [ | ] | Mental Health Community Residence  |
| []  | Substance Abuse & Dependence          | [ | ] | 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

|   | Please | respond to all of the following questions:   |
|---|--------|--|
|   | 1.     | Facility "d/b/a" (doing business as) Name Southur New England 860489-5500  |
| , |        | Business Address City State Zip Code Telephone   |
|   |        | Same as above  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.   |
|   |        | Level of Care N/A Hemodialysis Stations Bassinets (if applicable)  |
|   |        |  |
|   | 3.     | Olo 0 2 6 3 5 6 5 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  |
|   |        | Business Address  City State Zip Code Telephone  CELLA INTERPREDICT OF THE STATE OF |
|   |        | Mailing Address (if applicable)  |
|   | 5.     | Is the above named legal entity a (please check the box which applies):  |
|   |        | [ ] Individual/Sole proprietor [ ] Municipality  |
|   |        | [ ] General Partnership [ ] Trust [ ] Limited Partnership [ ] Profit Corporation [ ] Limited Liability Company [ ] Other:  |
| ) | 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  |

|           | Page 3 of 4   |
|-----------|---|
|           | lease disclose the name, business address and telephone number of the Agent for Service for the   |
| N.        | Judy Tabar 345 Whithey are New Haven, CT06511 ame Address 203-865-5158. Telephone   |
|           | ttach an organizational chart which reflects the current ownership structure of the licensee and the censee's relationship with the facility/agency.  |
|           | espond to the specific question that reflects the ownership structure of the licensee. The Licensee is ne 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).   |
| В         | If the Licensee is a <u>trust</u> , complete Form 2 (attached) for the Licensee.  |
|           | i. Attach a list including the name, address and telephone number of all trustees.  |
| C         | If the Licensee is a <u>corporation</u> (profit or non-profit), complete Form 3 (attached) for the Licensee. Complete a separate Form 3 for each additional corporate entity having 10% or greater ownership interest in the Licensee.  |
|           | <ul> <li>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.</li> <li>ii. Attach a list including the name, address and telephone number of all officers and all directors of the corporation.</li> </ul>                        |
| <u>In</u> | ttach a current copy of the facility's Certificate of malpractice and public liability insurance. (Note: aformation Pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be excepted.). Please note that All Behavioral Health levels of care, except hospitals, and RCH facilities are exempt from the malpractice requirement. |
| 11. Ar    | ttach evidence of current compliance with the worker's compensation insurance coverage equirements 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   |
| В.        |   |

12. Ownership of Real Property FLIS LICAPP -001

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

of the Conn. General Statutes; or

be accepted.)

Rev. 8/13

C.

# 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

٨

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

Planned Parenthood of Southern New England

٨

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



#### STATE OF CONNECTICUT

# DEPARTMENT OF PUBLIC HEALTH FACILITY LICENSING & INVESTIGATIONS SECTION

#### FORM 3

| FA  | ACILITY/AGENCY NAME: PCUMED FOLLOW  | Lhoock_  |
|-----|---|--|
|     | orm 3 must be completed if the facility/agency or Real Property Own-profit). Please copy additional sheets if necessary.  | ner is owned/operated by a corporation (profit or  |
| ow  | or each stockholder with a 10% or greater ownership interest in the Lice<br>orner owns 10% or more of the total shares, please indicate the two large<br>och legal entity listed below that is not an individual. |  |
| Thi | Licensee Real Property Owner  |  |
| 1.  | Name:   |  |
|     | Address: Telephone:   |  |
|     | Stockholder's percentage of ownership: Stockholder's occupation with the owner:   |  |
| 2.  | Name:   |  |
|     | Address:  |  |
|     | relephone:  |  |
|     | Stockholder's percentage of ownership: Stockholder's occupation with the owner:   |  |
| 3.  | Name:   |  |
|     | Address:  |  |
|     | Telephone:  |  |
|     | Stockholder's percentage of ownership:  | I SELLVISION   |
|     | Stockholder's percentage of ownership: Stockholder's occupation with the owner:  Name:  | D) is sign is in   |
| 4.  | Name:   | JAN 09 2019  |
|     | Address:  | Krawn51  |
|     | relephone.  | The second secon |
|     | Stockholder's percentage of ownership:  |  |
|     | Stockholder's occupation with the owner:  |  |

| - | ACORD         |
|---|---------------|
| • | THIS CERTIFIC |
|   | CERTIFICATE   |
|   | BELOW. THIS   |
|   | REPRESENTA    |
|   |               |

#### CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DDMYYY) 12/31/2013

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

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(les) 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 confor rights to the cartificate holder in liqu of such endorsement(s).

| PRODUCER Marsh USA, Inc. 1168 Avenue of the Americas New York, NY 10038 | CONTACT NAME: PHONE (A/C, No. Exit: E-MAN. ADDRESS:  | PHONE (A/G, No.): |  |  |  |  |
|---|--|-------------------|--|--|--|--|
| Alth: healthcare.accountscss@marsh.com Fax: 212-948-1307                | INSURER(8) AFFORDING COVERAGE  | NAIO #            |  |  |  |  |
| 109210-NIP-CAS-14-16 NEW,C GLPL   | INSURER A: Markel Insurance Company  | 38970             |  |  |  |  |
| INSURED PARENTHOOD OF   | INSURER O , N/A  | N/A               |  |  |  |  |
| SOUTHERN NEW ENGLAND, INC.  | RISURER C: National Union Fire Ins. Co. of Pillsburgh, PA  | 19445             |  |  |  |  |
| AN AFFILIATE OF PLANNED PARENTHOOD<br>FEDERATION OF AMERICA, INC.       | INSURER D:   |                   |  |  |  |  |
| 345 WHITNEY AVENUE  | INGURER E:   |                   |  |  |  |  |
| NEW HAVEN, CT 08511   | INSURER F:   |                   |  |  |  |  |
| ACTUAL ACTOR APPROPRIATE MINE   | DEVICE DEVICE DEVICE DEVICE DE LA CONTROL DE |                   |  |  |  |  |

CUVERAGES

CERTIFICATE NUMBER: NYC-005767681-26

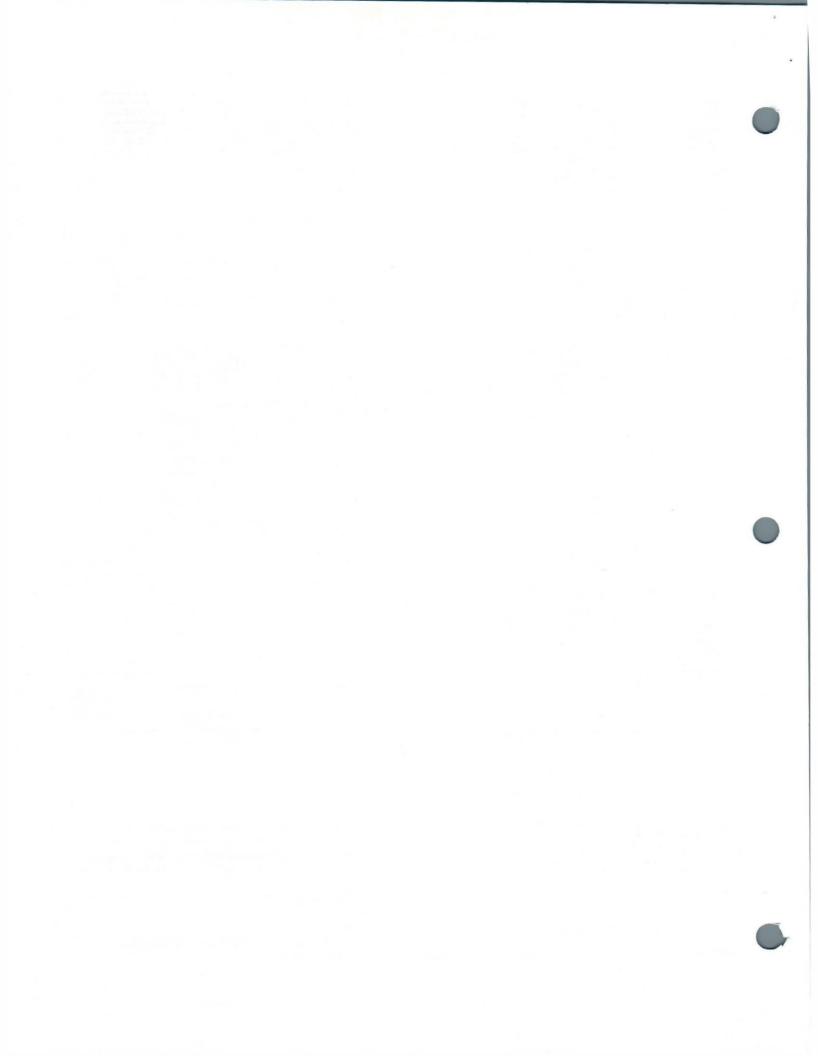
REVISION NUMBER: 11

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<br>LYR | TYPE OF INSURANCE   | INSR WV     | POLICY NUMBER  | POLICY EFF             | POLICY EXP   | LIMIT                                  | 6  |             |
|-------------|---|-------------|--|------------------------|--------------|--|----|-------------|
| A           | GENERAL LIABILITY   |             | 3C41034  | 01/01/2014             | 01/01/2015   | EACH OCCURRENCE                        | \$ | 1,000,000   |
|             | X COMMERCIAL GENERAL LIABILITY                            |             |  |                        |              | PREMISES (Ea pocurence)                | \$ | 100,000     |
|             | CLAIMS-MADE X OCCUR                                       |             | 1  |                        |              | MED EXP (Any one person)               | \$ | 5,000       |
|             | X SIR: \$100,000  |             | PERSONAL & ADV INJURY  | \$                     | 1,000,000    |  |    |             |
|             |   |             |  |                        |              | GENERAL AGGREGATE                      | \$ | 2,000,000   |
| 1           | GENL AGGREGATE UMIT APPLIES PEN:                          |             | No. of the contract of the con |                        |              | PRODUCTS - COMPIOE AGG                 | 8  | 2,000,000   |
|             | POLICY SECT X LOC   |             |  |                        |              |  | \$ |             |
|             | AUTOMOBILE LIABILITY                                      |             |  |                        |              | COMBINED SINGLE LIMIT<br>(Fa socideni) | s  |             |
|             | ANYAUTO   |             |  |                        | 1            | BODILY INJURY (Per person)             | 8  |             |
|             | ALL OWNED AUTOS NON-OWNED                                 | 1 1         |  |                        |              | BODSLY INJURY (Per accident)           | \$ |             |
|             | HIREDAUTOS NON-OWNED                                      |             |  |                        |              | PROPERTY DAMAGE                        | 5  |             |
| $\Box$      |   |             |  |                        |              |  | S  |             |
|             | UMBRELLA LIAB OCCUR                                       |             |  |                        |              | EACH OCCURRENCE                        | 5  |             |
|             | EXCESS LIAD CLAIMS-MADE                                   | 1 1         |  |                        |              | AGGREGATE                              | \$ |             |
|             | DEO RETENTIONS  |             |  |                        |              |  | \$ |             |
|             | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY             |             |  |                        |              | WO SYATU- OTH-                         |    |             |
|             | ANY PROPRIETOR PARTNER EXECUTIVE OFFICER MEMBER EXCLUDED? | HIA         |  |                        |              | E.L. EACH ACCIDENT                     | \$ |             |
|             | (Mandatory in NH)   | """         |  |                        | 1            | E.L. DISEASE - EA EMPLOYEE             | \$ |             |
|             | If yes, describe under<br>DESCRIPTION OF OPERATIONS MINW  |             |  |                        |              | E.L. OISEASE - POLICY LIMIT            | 8  |             |
| C           | MEDICAL PROFESSIONAL                                      |             | 8793288  | 01/01/2014             | 01/01/2015   | PERCLAIM                               |    | \$1,000,000 |
|             | CLAIMS-MADE COVERAGE                                      |             | Program Retro Date: 11/1/76  |                        |              | AGGREGATE                              |    | \$3,000,000 |
| DESC        | RIPTION OF OPERATIONS / LOCATIONS / YENIC                 | LES (Attack | h ACORD 101, Adeluona) Remarks Sc  | hedde, if more space i | is required) |  |    |             |

| CERTIFICATE HOLDER   | CANCELLATION   |
|--|--|
| PLANNED PARENTHOOD OF SOUTHERN NEW<br>ENGLAND<br>ATTN: LOUIS DENEGRE<br>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. |
| NEW HAVEN, CY 06S11  | AUTHORIZED REPRESENTATIVE<br>of March USA Inc.   |
|  | Ricki Filzeimmone Ziel. Fig.   |

@ 1988-2010 ACORD CORPORATION. All rights reserved.



|  |            | ATE OF LIA   |  |                                  |  | 12/31          |               |
|--|------------|--|--|----------------------------------|--|----------------|---------------|
| THIS CERTIFICATE IS (SSUED AS A DERTIFICATE DOES NOT AFFIRMATION THIS CERTIFICATE OF INSTRUMENTATIVE OR PRODUCER, A IMPORTANT: If the capilificate holder  | WELY OF    | R NEGATIVELY AMEND, I DOES NOT CONSTITUT DERTIFICATE HOLDER, | TE A CONTRACT                          | ETWEEN T                         | HE ISSUING INSURER   | S), AU         | THORIZED      |
| the terms and conditions of the policy<br>cartificate holder in lieu of such andon   | gertain !  | policies may require an er                                   | idosement. A stat                      | entant on thi                    | s certificate does not o                                       | anfar r        | ights to the  |
| Peoplicitit  |            |  | CONTACT                                |                                  | TEAV   |                |               |
| March USA, Inc.<br>1168 Avenue of the American   |            |  | PHONE ENG:                             |                                  | FAX<br>(A/G, Ne)1  |                |               |
| Herr York, MY 10038 After the althouse accounts case @manufacount Fish: 212-   | 949-1307   |  | ACCRESSA                               |                                  |  |                |               |
|  |            |  | 1 le ded hos                           | nireria) appor<br>Endnog Company | DIRG COVERAGE  | _              | 38970         |
| 109210-NBCAS-14-16 NEW,O   | GLPL       |  | Industry India                         | Handa amidrad                    |  | -              | HVA           |
| PLANNED PARENTHOOD OF  |            |  | INCURER O : Naforel U                  | nion Fire Inc., Co.              | of Phinburgh, PA   |                | 19445         |
| AN APPLIATE OF PLANNED PARENTHOOD  |            |  | INSURER DI                             |                                  |  |                |               |
| FEDERATION OF AMERICA, INC.<br>346 WHITNEY AVENUE<br>NEW HAMEN, CT 06511   |            |  | THEURER ST                             |                                  |  |                |               |
| NEW HAVEN, CT 06511  |            |  | industrés                              |                                  |  |                |               |
| COVERAGER CEL  | TAPIFICAT  | E NUMBER:  | NYC-005757661-26                       |                                  | REVISION NUMBER: 11  |                |               |
| THIS IS TO CERTIFY THAT THE POLICIES INDICATED. NOTWITHSTANDING ANY REDETIFICATE MAY BE ISSUED OR MAY EXCLUSIONS AND CONDITIONS OF SUCH  | PERTAIN    | ENT, TERM OR CONDITION THE INSURANCE AFFORD                  | OF ANY CONTRACT                        | OR OTHER                         | HEREIN IS SUBJECT TO   |                | WHILE I I HOS |
| TYPE OF WISURANCE  | ADDLISUB   | POLICY NUMBER  | POLICY EFF                             | INMODATES                        | LIAN   | 18             |               |
| A GENERAL LIABILITY  | 1          | 20(1024  | 0101/2014                              | 01/01/2015                       | SACH OCCUPRONOR  | 1              | 1,000,000     |
| X COMMERCIAL GENERAL MARILITY  |            |  |  |                                  | PREMISES (Fe occurrence)                                       | \$             | 100,000       |
| GLAMBHARDE X OCCUR   |            |  |  |                                  | HED EXP (Any one person)                                       | 5              | 6,000         |
| X Suft \$100,000   |            |  | 1                                      |                                  | PERSONAL & ADVINJURY   | 6              | 1,000,000     |
|  | 11         |  |  |                                  | GENERAL AGGREGATE  |                |               |
| GEHTL AGGREGATE LANT APPLIES PER   |            |  |  |                                  | PRODUCTS - COMPACE AGAI  |                | 2,000,000     |
| POLICY PRO X LOC   | -          |  |  |                                  | CONSINED SHIGLE LIMAT  | •              |               |
| AUTOGOBILE LIABILITY   |            |  | 1                                      |                                  |  | 5              |               |
| ALLOWIGO SCHEOULED   | 11         |  |  |                                  | BODILY IN JURY (Per person)  BODILY IN JURY (Per accident)     | -              |               |
| AUTOS  | 11         |  |  |                                  | PROPERTY DAMAGE<br>IP or problems                              | \$             |               |
| HARED AUTOS AUTOS  | 1 !        |  |  |                                  | [Per pooldents   | 3              |               |
| SIMBRELLA LIMB OCCUR   |            |  |  |                                  | EACH OCCURRENCE  | 3              |               |
| EXCESS LIAB CLAIMS-MADE  | 1          |  |  |                                  | AGGREGATE  | 3              |               |
| DED RETENTIONS   | 1          |  |  |                                  |  |                |               |
| WORKERS GOMPERSADON<br>AND ENGLOYERS LABOUTY   |            |  |  |                                  | Jag si Vior  |                |               |
| OFFICEMENT PLONDS TO WASHINGTON TO WASHINGTON TO WASHINGTON THE WASHINGTON TO WASHINGT | HIA        |  |  |                                  | E.L. EACH ACCIDENT   | 8              |               |
| thrandalogy in Nell  |            |  |  |                                  | E.L DISEASE - EA ENPLOYER                                      | 3              |               |
| DESCRIPTION OF OPERATIONS below  | $\vdash$   |  |  |                                  | B.L. DISEASE - POLICY LIMIT                                    | 4              |               |
| C WEDICAL PROFESSIONAL   |            | \$793285   | 01/01/2014                             | 01/01/2016                       | PER CLAM   |                | \$1,000,000   |
| CLAIMB (MIDE COVERNOE  | 11         | Program Retro Dale: 1171/76                                  |  |                                  | AGGREGATE  |                | \$3,000,000   |
| Propertion of Grenations (Locations (Vehic   | ZEG JAHLIC | n ACORD 101, Aédibonal Flamais                               | Schadula, il mura sprov l              | e respices)                      |  |                |               |
| CERTIFICATE HOLDER   |            |  | CANCELLATION                           |                                  |  |                |               |
| PLANNED PARENTHOOD OF SOUTHERN NEW<br>ENGLAND<br>ATTN: LOUIS DENEIGRE<br>345 WHITNEY AVENUE<br>HIGH HEARDER OF SORES   |            |  | ACCORDANCE W                           | N DATE THE                       | esonibed policies se o<br>ereor, notice will<br>ey provisions. | ANGÉL<br>BR PR | LED SEFORÉ    |
| NEW LIAVEN, CT 08511   |            |  | AUTHORISED KEPMEN<br>of March USA Inc. | entAmple                         |  |                |               |
|  |            |  | Riold Fitzelmmons                      | an ana                           | List Stan  |                | bla and delay |
| ACORD 26 (2010/08)   | The A      | CORD name and logo a   |  |                                  | ORD CORPORATION.   | All rig        | nus reserved. |

| **** | ************   | **************************************   |
|------|--|--|
|      | CHECK #  | AMOUNT \$  |
|      | DATE RECEIVED  | INITIALS   |
| **** | **********   | **************   |
| 13.  | Marshal. NOTE: <u>Hospitals</u> must have completed for each building on the license. Additional forms may be co   | nspection Form (attached) must be completed by the Local Fire we a separate Fire Marshal's Certificate of Inspection nospital's campus and each satellite listed on the hospital's epied if necessary. Each completed Fire Marshal's mitted must have an original signature. (Not applicable for the Health Agencies).   |
| 14.  |  | within this application is true and accurate and that any changes eported to the Department as required by law.  |
|      | Signature Jahan  | Date Signed  |
|      | Check one as applicable:   |  |
|      | <ul> <li>[ ] Individual/Sole Proprietor</li> <li>[ ] General/Managing Partner</li> <li>[ ] President of Corporation</li> <li>[ ] Secretary of Corporation</li> <li>[ ] Municipal Officer</li> <li>[ ] Trustee</li> </ul> | DECEUVED JAN 09 2018   |
|      | State of Connecticut )   | THE SHAPE IN THE PLANT OF THE PARTY OF THE P |
|      | County of New Have )   | ss 12/15 20_13   |
|      | Personally appeared before me the abo to the truth of the statements contained Sally Hellerman Notary Public-Connecticut My Commission Expires December 31, 2016   | Notary Public Justice of the Peace Town Clerk Commissioner of the Superior Court [ ]   |

(If Notary Public) FLIS LICAPP -001 Rev. 8/13

My Commission Expires:

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

**Torrington** 

City or Town:



#### Gity of Torrington Office of the Fire Marshal Torrington, Ct. 06790



| On      | 2/4/2014         | , The City of _                       | Torrington   | _Office of the Fire Marsh  | nal conducted an           |
|---------|------------------|---------------------------------------|--|--|----------------------------|
| inspec  | tion of PLAN     | NED PARE                              | NTHOOD   |  |                            |
| located | d at (address)   | 249                                   | Winsted Rd   |  | in the                     |
| City/To | own of           | Torringto                             | on to de   | etermine the degree of o   |                            |
| fire sa | fety requiremen  |                                       |  | hapter 541 as authorized b   |                            |
| Section | n 29-305 of the  | statutes. This f                      | acility was evaluated                              | as a (new/existing)  | Existing                   |
| (occup  | ancy classificat | ion)                                  | Business   | as clas  | sified                     |
|         | CONNECTICU       |                                       | ΓΥ CODE. As a resu                                 | lt of this inspection, the fo  | ollowing                   |
|         |                  |                                       |  |  |                            |
| (I)     | At the of ins    | pection/pocod<br>d.                   | e violations were ide                              | ntified. Certificate of appr   | roval                      |
| II.     | requirements     | of these codes                        | onditions were discovered. An acceptable plan      | rered to be contrary to the of correction was submitt recommended.   | minimum<br>ed. <i>(See</i> |
| III.    | At the time o    | f inspection, co                      | onditions were discov                              | ered to be contrary to the r<br>roval NOT recommend  | ninimum<br>ed.             |
| IV.     | Attorney for t   | currently seeking<br>the purpose of o | ng an injunction from<br>of closing or restricting | overed at the time of this is<br>the court through our Tov-<br>ig usage of this facility to to<br>val NOT recommended. | vn/City                    |
| - 4     | 1-1              |                                       |  |  |                            |
| JU/     | 1/2              |                                       |  |  | 2/4/2014                   |
| re Mar  | rshal            |                                       |  |  | Date Signed                |

2/5/2015



# DEPARTMENT OF PUBLIC HEALTH FACILITY LICENSING & INVESTIGATIONS SECTION

#### LICENSURE APPLICATION - ADDITIONAL INFORMATION REQUIRED

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

| Please | e respond to all of the following questions:   |
|--------|--|
| 1.     | Planned Parenthood of Southern New England<br>Facility "d/b/a" (doing business as) Name  |
|        | Business Address  City State Zip Code Telephone  |
| 2.     | Check the appropriate box/boxes describing the services to be provided by the clinic:  [ ] Primary Care [ ] Well Child Clinic [ ] Abortion Procedures [ ] Dental |
| 3.     |  |
| 3.     | Administrator (Your name needs to appear as it is shown on your Professional License).   |
| 4.     | Timothy Spurrell M.D.  Medical Director  Dental Director (if applicable)   |
|        | (Your name needs to appear as it is shown on your Professional License).   |
| 5.     | Hours of Operation: M 10-6, T 9:30-4:30 WED-CLOSE BITH VIO-6 F:8:30-   |
| 6      | Please provide a list of services that will be provided.  JAN 0 9 2018   |
| 7.     | Business Fax Number: 800 4961754   |
| 8.     | Business Email Address: tammy, weha aposve. org  |
| 9.     | Business Cell Phone Number with Texting capabilities of the Administrator: 203-5959496   |
|        | 1  |
|        | Signature of Administrator Date Signed   |

|                                 |  |   |  | - December 16, 2013  |  |  |
|---------------------------------|--|---|--|--|--|--|
| CENTED MANAGED                  | BRIDGEPORT   | DANBURY   |  | ENFIELD  | HARTFORD NORTH                                     | Sandy Downill  |
| CLINICIAN                       | Vensse Silva Laure Haydu Linda Magee Diana Soto, PD                                      | Antonietta Schaalman<br>Jennifer Ryan   | Brittney Schultz<br>Lindsay Delaire<br>Lisa Marie Griffiths, PD    | Cartin Murphy Chris Bachand Christina Fantoni, PD Any Keneflok, PD             | Heather Deliago<br>Debbie Hamer                    | Sandy Dowell Maria Banevictus Diane Libby-Ramage Kristine Sterling, PD   |
| RN                              |  |   |  |  |  |  |
| CA.                             | Latisha Ervin (float) Ornar Jehaludi Nikole Moya Tenisa Paulding, PD Michelle Reid, PD   | Anntreen Lamar  | Stephanie Nix<br>Sheri Saddlemire                                  |  | Sursattle Nepal<br>Taniesha Prado<br>Natacha Roman | Briager Tomezak<br>Brianne Johnson   |
| ADVANCED CA                     | Amber Bachman Evelyn Cuevas* Lori Gall Aida Ortega* Karl Peters, PD Latlesha Purifoy, PD | Gabriela Ambrose*<br>Jennifer Tomasini  | Jacklyn Michalski, PD  | Jernifer Bouley Danielle Deschaine   | Yolanda Young                                      | Shondra Bechtold<br>Leah Bell<br>Nicolette Laume<br>Norimar Nieves*  |
| REGIONAL DIRECTOR               | Kelly O'Brien  | Kelly O'Brien   | Shira Revzen   | Shira Revzen   | Shira Revzen                                       | Shira Revzen   |
|                                 | MERIDEN/NEW BRIT   | NEW HAVEN   | NEW LONDON   | NORWICH  | OLD SAYBROOK                                       | PROVIDENCE   |
| CLINICIAN                       | Samantha Dobson Loren Fields Kathy Bryson Jenna LoGiudice, PD                            | Jody Clark Kirsten Asmus Carrie Ferrigno Janet Gumaer Wei-TI Chen, PD Constance Chrinta, PD Gina Novick, PD Lesile Robinson, PD Margaret Withington, PD Margaret Withington, PD | Lisa Hodges-Velasquez<br>Sarah Whalen<br>Edle Morren-Morrison, PD  | Janeen Oritz* Kris Robin Stephanie Malia, PD                                   | Beth Burrage<br>Elizabeth Fabrizi                  | Danina Freedman-Shara<br>Stacy Ramsey<br>Jessica Wilder<br>Stephanie Avilla, PD<br>Melanie Hill, PD<br>Constance Chang, PD<br>Megan Gaynor Charette*, PD |
| RN<br>T                         |  | LaToya Ward<br>Erin Paduda<br>Sarah Acker, PD<br>Pamela Lee, PD<br>Sari Gottlieb-Sherman, PD  |  |  |  | Paula Golden<br>Paulina Niechdal, PD<br>Amy Gordon, PD   |
| LPN                             | Daiva Morales*   |   |  | Elaine Robinson  |  |  |
| <b>V</b>                        | Arlinda Carr<br>Casandra Lehr  | Hector Cotto<br>Whitney Davis<br>Chelsea Epps<br>Mercy Plant  | Tylisha Wrighten   | Hannah Carey<br>Stephen Polach<br>Jessica Stefanski                            |  | Jessa Galdstein<br>Kayla Murphy<br>Arrber Newmann<br>Tara Patterson<br>Pam Shaw<br>Harriet Singer<br>Nind Tiemo<br>Brianna Jolaoso                       |
| ADVANCED CA                     | Keri Geoghegan<br>Viviana Hernandez<br>Tina St. Germain<br>Jose Vargas                   | Victoria Burch Omara de la Cruz Eshe Hamilton Candice Langley Esther Pellor Camen Trochez Minde Zulo  | Bernadette DeShields Damaris Hemandez* Lindsey Jones Veronica Sohn | Donna Bonanno<br>Jessica Davila*   | Nicole Corona<br>Susan Schlachter                  | Antigone Reyes<br>Esperanza Santana*<br>Eni 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<br>CLINICIAN     | Machicia Carolus** Garnon Ward Ines Riera, PD Susan Ruehl, PD                            | Tammy Hieha Claudette Baril   | Alicia Caban*<br>Ronnie Dubrowin*<br>Karen Parkhurst, PD           | Jane Yousman<br>Mark Pierce<br>Raeanne DePasquale<br>Errily Cote, PD           | Beth Murana<br>Jill Cassells                       |  |
| RN                              | Allison Lomas<br>Michelle Miller, PD<br>Miren Katixa Abotitz, PD:                        |   |  | Kate Sivel*<br>Samantha Hyacinth, PD<br>Emily Yeast, PD                        |  |  |
| CA                              | Anabel Morel-Rodriguez<br>Catherine Osorio<br>Yolanda Rosado*                            | Jernifer Helt<br>Heather Keyes  | Michelle Jimenez*<br>Claudia Polanco                               | Emily Kersey<br>Jetsebel Lopez<br>Morayma Rodriguez                            | Jillian Librandi<br>Franceska Vega                 |  |
| ADVANCED CA                     | Mayra Torres* Evinn Jackson, PD Daphne Mondesir*, PD                                     | Jasmine Osorio  | Erika Vanamringe<br>Ivelisse Vasquez*                              | Madeline Alvarez* Mary Cruz* Getzenia Nieves* Wendy Trella Jenny Martoreli, PD | Lillian Morales*                                   |  |
| REGIONAL DIRECTOR Kelly O'Brien | Kelly O'Brien  | Kelly O'Brien   | Kelly O'Brien  | Shira Revzen   | Shira Revzen                                       | П  |



### Serving Connecticut & Rhode Island

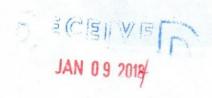
#### BOARD OF DIRECTORS, 2012-2013

#### OFFICERS:

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

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Leigh Bonney
Erica Buchsbaum
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Donna Moffly
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Sandra Wagenfeld



March 2010

# RENEWAL

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Kay Maxwell, Chair
Deborah Freedman, Vice Chair
ria Cruz-Saco, Ph.D., Secretary
lelia Renkert-Thomas, J.D., Treasurer
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**Administrative Headquarters** 

345 Whitney Avenue New Haven, CT 06511 203.865.5158

111 Point Street Providence, RI 02903

www.ppsne.org



Serving Connecticut & Rhode Island

January 8, 2010

Attn: Rose McLellan, Licensing Examination Assistant State of Connecticut
Department of Public Health
Division of Health Systems Regulation
410 Capitol Avenue – MS # 12HFL
P O Box 340308
Hartford, CT 06134

Re: License Renewal Application - Torrington Center

Dear Ms. McLellan:

Enclosed you will find the License Renewal Application for our center in Torrington. I wanted to let you know that we do not have regularly scheduled hours for patients on Wednesdays. Also we are expecting a visit from our Fire Marshall in the upcoming weeks so when he does come and renew our certificate I will forward that to you.

If there are any problems or questions with regard to this renewal, please give me a call. Thanks for your attention.

Sincerely, January Huha a

Tammy Hreha Center Coordinator





# DEPARTMENT OF PUBLIC HEALTH FACILITY LICENSE & INVESTIGATIONS SECTION

#### LICENSURE APPLICATION

[ ] INITIAL RENEWAL

| NOTE: A separat    | e application must be completed for each licensed level of care which is located at a |
|--------------------|---|
| different address. | One (1) application may be submitted for multiple levels of care provided each leve   |

of care has the same name and the same licensee and is located at the same address.

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

| Assisted Living Services Agency                   | [ ] Infirmary Operated by an Educational Institution |
|---|--|
| [ ] Children's Hospital                           | [ ] Maternity Home                                   |
| [ ] Chronic and Convalescent Nursing Home         | Maternity Hospital                                   |
| [ ] Chronic Disease Hospital                      | [ ] Outpatient Clinic                                |
| Family Planning Clinic                            | [ ] Outpatient Dialysis Unit                         |
| [ ] General Hospital                              | [ ] Outpatient Surgical Facility                     |
| [ ] Home Health Care Agency                       | [ ] Residential Care Home                            |
| [ ] Homemaker-Home Health Aide Agency             | [ ] Rest Home with Nursing Supervision               |
| [ ] Hospice                                       | [ ] Well Child Clinic                                |
| [ ] Hospital for Mentally III Persons             | [ ] Mental Health Day Treatment                      |
| [ ] Mental Health Psychiatric OutPat.             | [ ] Mental Health Community Residence                |
| [ ] Mental Health Intermediate Tmt.               | [ ] Mental Health Residential Living                 |
| [ ] Substance Abuse & Dependence                  |  |
|   |  |
| Please respond to all of the following questions: | SY 520   |
| Please respond to all of the following questions: | The second second                                    |
| 1. Planned Parenthoo                              |  |
| Facility "d/b/a" (doing business as) Name         | O THOU SULDE   |
|   | 860496-8405  |
| 249 Winsted Road                                  | - location CT No 790                                 |
| Business Address City                             | State Zip Code Telephone                             |
|   | state 21p code a crepnone                            |
| same as above                                     | •  |
| Mailing Address (if applicable) City              | State Zip Code                                       |
|   |  |



Phone: (860) 509-7444

<u>Telephone Device for the Deaf (860) 509-719</u>

410 Capitol Avenue - MS # 12HFL

P.O. Box 340308 Hartford, CT 06134

An Equal Opportunity Employer

| 2. | Bed Capacity Requested (if please list the bed capacity    | applicable). If submitting for each level of care being the contract of the care being the care  | g this application for multiple<br>ng requested.  | e levels of care,     |
|----|--|--|---|-----------------------|
|    | Level of Care N/A  | Beds/<br>Hemodialysis Stations   | Bassinets (if applicab                            | le)                   |
|    |  |  |   |                       |
|    |  |  |   |                       |
|    |  |  |   |                       |
| 3. | Federal Employer Identific                                 |  |   |                       |
| 4. | Disclose the legal entity whentity.)                       | nich owns/operates the fac   | cility. (Note: The license wi                     | ll be issued to this  |
|    | Planned Pare   | enthood of S   | bouthern New                                      |                       |
|    | 249 Win Ste<br>Business Address                            | d Rd Torrin  | gton CT 0670<br>State Zip Code Teleph             | 800-<br>10 496840S    |
|    | Mailing Address (if applica                                | able)  | S - C   | 200                   |
| 5. | Is the above named legal en                                |  | ox which applies):                                | REC                   |
|    | [ ] Individual/Sole propri                                 | etor   | [ ] Municipality                                  | EIVED<br>2 A 2:       |
|    | [ ] General Partnership<br>[ ] Limited Partnership         |  | [ ] Trust<br>[ ] Profit Corporation               | 2 [                   |
|    | [ ] Limited Liability Com                                  | pany   | [ ] From corporation                              | ED 2:46               |
|    | Non-profit Corporatio                                      | n  |   |                       |
|    | Is the above named entity a<br>State of Connecticut and co | The state of the s | f the Secretary of State to trang? [ ] YES [ ] NO | nsact business in the |
|    | Please disclose the name, b                                | ousiness address and telep   | hone number of the Agent fo                       | r Service for the     |
|    | Judy Tabar 3<br>Name                                       | 45 Whitney A   | tve New Haven<br>55158 Teleph                     | 06511                 |
|    |  |  | rent ownership structure of the                   |                       |
|    | licensee's relationship with                               | the facility/agency.   |   |                       |
|    |  | FACILIT  | TY FAX # 860 49617                                | 54                    |

- 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 and all directors of the corporation.
- 10. Attach a current copy of the facility's Certificate of malpractice and public liability insurance. (Note: Information Pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.). Please note that All Behavioral Health levels of care, except hospitals, and RCH facilities are exempt from the malpractice requirement.
- 11. Attach evidence of current compliance with the worker's compensation insurance coverage requirements in the form of one of the following:
  - A. a certificate of self-insurance issued by a worker's compensation commissioner pursuant to Section 31-284 of the Conn. General Statutes; or
  - B. a certificate of compliance issued by the Insurance Commissioner pursuant to Section 31-286 of the Conn. General Statutes; or
  - C. a Certificate of Insurance issued by any stock or mutual insurance company or mutual association authorized to write worker's compensation insurance in this state. (Note: Information pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.)

12. Ownership of Real Property
Planned Parenthoocl of Southern New England
Name
249 WinSted Rd. Torrington, CT 06790 866496-8405
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).

|      |  | FOR OFFICE USE ONLY  |
|------|--|--|
|      | CHECK #  | AMOUNT \$  |
|      | DATE RECEIVED  | INITIALS   |
| **** | *************  | ****************   |
| 14.  | Affidavit of Owner: I attest that the information provided in the information submitted will be re   | within this application is true and accurate and that any changes eported to the Department as required by law.  |
|      | Signature Jahan  | Date Signed  |
|      | Check one as applicable:   |  |
|      | <ul> <li>[ ] Individual/Sole Proprietor</li> <li>[ ] General/Managing Partner</li> <li>[ ] President of Corporation</li> <li>[ ] Secretary of Corporation</li> <li>[ ] Municipal Officer</li> <li>[ ] Trustee</li> </ul> | RECEIVED  2010 JAN 12 A 2: 46  DEPT OF PHYSICAL ALL ALL AND SYSTEM SHEET |
|      | State of Connecticut )   | 6  |
|      | County of New Haven  | ss December 21 2009  |
|      | Personally appeared before me the abo  | ove named Judy Tabas and made oath in his/her answers to the foregoing questions.  |
|      | My Commission Expires: (If Notary Public)  | Sulf Afeller  Notary Public [7]  Justice of the Peace [7]  Town Clerk [7]  Commissioner of the Superior Court [7]  |

Attachment 3



#### STATE OF CONNECTICUT

# DEPARTMENT OF PUBLIC HEALTH FACILITY LICENSING & INVESTIGATIONS SECTION

FORM 3
FACILITY/AGENCY NAME: Planned Parenthood

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:  Real Property Owner |          |
|------|--|----------|
| 1.   | Name:                                    |          |
|      | Address:                                 |          |
|      | Telephone:                               |          |
|      | Stockholder's percentage of ownership:   |          |
|      | Stockholder's occupation with the owner: |          |
| 2.   | Name:                                    |          |
|      | Address:                                 |          |
|      | relephone:                               |          |
|      | Stockholder's percentage of ownership:   |          |
|      | Stockholder's occupation with the owner: |          |
| 3.   | Name:                                    |          |
|      | Address:                                 | (n) (e)  |
|      | Telephone:                               |          |
|      | Stockholder's percentage of ownership:   |          |
|      | Stockholder's occupation with the owner: | SSS IN M |
| 4.   | Name:                                    | 12 6     |
|      | Address:                                 |          |
|      | Telephone:                               |          |
|      | Stockholder's percentage of ownership:   | EAF N M  |
|      | Stockholder's occupation with the owner: | S H L D  |



## 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  249 Winsted Rd Torrington CT 06790  Business Address  City State Zin Code Telephone   |
|        | 249 Winsted Rd Torrington CT 06790 800 4968405 Business Address City State Zip Code Telephone  |
| 2.     | Check the appropriate box/boxes describing the services to be provided by the clinic:  |
|        | [ ] Primary Care [ ] Well Child Clinic [ ] Dental  [ ] Family Planning [ ] Abortion Procedures   |
| 3.     |  |
|        | Administrator (Your name needs to appear as it is shown on your Professional License).   |
| 4.     | Lester Silberman 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 10-6, T 9:30-4:30 W-CLOSED TH-10-6, F-8:30-  |
| 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 Date Signed   |
|        |  |

|  | ACORD. CERTI  | FICATE OF LIABIL   | ITY INSU                           | JRANCE  |                                      | DATE (MM/DD/YY) |  |
|--|---|--|------------------------------------|---|--------------------------------------|-----------------|--|
|  | DDUCER  | TOTTE OF EINER   |                                    | THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION   |                                      |                 |  |
| W                                      | ORKERS' COMPENSATION OF BOX 5042  | ON TRUST   | ONLY AN                            | ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.                         |                                      |                 |  |
| Wallingford, CT 06492<br>(203)678-0105 |   |  |                                    | INSURERS AFFORDING COVERAGE   |                                      |                 |  |
|  | IDED  | thood of CT, Inc.  | INSURER A: W                       | orkers' Co  | ompensation Tr                       | ust             |  |
|  |   |  | INSURER B:                         |   |                                      |                 |  |
|  | 345 Whitney A   |  | INSURER C:                         |   |                                      |                 |  |
|  | New Haven, CT   | 06511  | INSURER D:                         |   |                                      |                 |  |
|  | OVERAGES  |  | INSURER E:                         |   |                                      |                 |  |
| T A                                    | HE POLICIES OF INSURANCE LISTEI<br>MY REQUIREMENT, TERM OR CON<br>MAY PERTAIN, THE INSURANCE AFFO | D BELOW HAVE BEEN ISSUED TO THE II<br>DITION OF ANY CONTRACT OR OTHER<br>DRDED BY THE POLICIES DESCRIBED H<br>IN MAY HAVE BEEN REDUCED BY PAID | DOCUMENT WITH<br>HEREIN IS SUBJECT | RESPECT TO WHI  | CH THIS CERTIFICATE MA               | Y BE ISSUED OR  |  |
| INSF                                   |   | POLICY NUMBER  |                                    | POLICY EXPIRATION   | N LIM                                | ITS             |  |
|  | GENERAL LIABILITY   |  | DATESMINISTRA                      | DATE (MMIDD/11)   | EACH OCCURRENCE                      | s               |  |
|  | COMMERCIAL GENERAL LIABILITY  |  |                                    |   | FIRE DAMAGE (Any one fire)           | \$              |  |
|  | CLAIMS MADE OCCUR   |  |                                    |   | MED EXP (Any one person)             | \$              |  |
|  | 4   |  |                                    |   | PERSONAL & ADV INJURY                | \$              |  |
|  |   |  |                                    |   | GENERAL AGGREGATE                    | s               |  |
|  | GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO- JECT LOC   |  |                                    |   | PRODUCTS - COMP/OP AGG               | \$              |  |
|  | AUTOMOBILE LIABILITY  ANY AUTO  |  |                                    |   | COMBINED SINGLE LIMIT (Ea accident)  | s               |  |
|  | ALL OWNED AUTOS SCHEDULED AUTOS   |  |                                    |   | BODILY INJURY<br>(Per person)        | s               |  |
|  | HIRED AUTOS NON-OWNED AUTOS   |  |                                    |   | BODILY INJURY<br>(Per accident)      | \$              |  |
|  |   |  |                                    |   | PROPERTY DAMAGE<br>(Per accident)    | \$              |  |
|  | GARAGE LIABILITY  |  |                                    |   | AUTO ONLY - EA ACCIDENT              | \$              |  |
|  | ANY AUTO  |  |                                    |   | OTHER THAN EA ACC                    |                 |  |
|  | EXCESS LIABILITY  |  |                                    |   | EACH OCCURRENCE                      | \$              |  |
|  | OCCUR CLAIMS MADE   |  |                                    |   | AGGREGATE                            | \$              |  |
|  |   |  |                                    |   |                                      | \$              |  |
|  | DEDUCTIBLE  |  |                                    |   |                                      | \$              |  |
| _                                      | RETENTION \$  |  |                                    |   |                                      | s               |  |
|  | WORKERS COMPENSATION AND<br>EMPLOYERS' LIABILITY  |  |                                    |   | X WC STATU-<br>TORY LIMITS OTH<br>ER | -               |  |
|  |   | WCP 394  | 01/01/09                           | 01/01/10  | E.L. EACH ACCIDENT                   | \$2,500,000     |  |
| A                                      |   |  |                                    |   | E.L. DISEASE - EA EMPLOYE            |                 |  |
|  | OTHER   |  |                                    |   | E.L. DISEASE - POLICY LIMIT          | \$2,500,000     |  |
| DESC                                   | RIPTION OF OPERATIONS/LOCATIONS/VE  | HICLES/EXCLUSIONS ADDED BY ENDORSEME   | ENT/SPECIAL PROVISIO               | DNS   | A 2:47 HEALTH                        | IVED            |  |
| CER                                    | TIFICATE HOLDER ADD   | TIONAL INSURED; INSURER LETTER:  | CANCELLAT                          | ON  |                                      |                 |  |
|  | Planned Parent  | hood of CT, Inc.   | SHOULD ANY O                       | CANCELLATION  SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION  DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 10 DAYS WRITTEN          |                                      |                 |  |
|  | 249 Winsted Road<br>Torrington, CT 06790  |  |                                    | 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 REF                     | PRESENTATIVE  | L. Ship                              | lee             |  |
| ACO                                    | RD 25-S (7/97) © ACORT CORPORATION 1988   |  |                                    |   |                                      |                 |  |

| 1     |
|-------|
| ACORD |
|       |

#### CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 12/18/2009

PRODUCER

Marsh USA, Inc. 1166 Avenue of the Americas New York, NY 10036 THIS CERTIFICATION IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

|    | - |   | - | _ | - |
|----|---|---|---|---|---|
| IN | s | u | к | E | D |

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

| INSURERS AFFORDING COVERAGE                               | NAIC# |
|---|-------|
| INSURER A: Markel Insurance Company                       | 38970 |
| INSURER B: National Union Fire Ins. Co. of Pittsburgh, PA | 19445 |
| INSURER C:  |       |
| INSURER D:  |       |
| INSURER E:  |       |

#### COVERAGES

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, AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUICED BY PAID CLAIMS

| INSR . | CONDITIONS OF SUCH POLICIES. AGGREGADD'L NSRD TYPE OF INSURANCE      | POLICY NUMBER  | POLICY EFFECTIVE DATE (MM/DD/YYYY) | POLICY EXPIRATION DATE (MM/DD/YYYY) | LIM   | ITS          |  |
|--------|--|--|------------------------------------|-------------------------------------|---|--------------|--|
| Α      | GENERAL LIABILITY  | 09GLP1007999   | 01/01/2010                         | 01/10/2011                          | EACH OCCURRENCE \$ 1,000,00                 |              |  |
|        | X COMMERCIAL GENERAL LIABILITY                                       | 1007000  | 01/01/2010                         | 01/10/2011                          | DAMAGE TO RENTED<br>PREMISES(Ea occurrence) | \$ 100,000   |  |
|        | CLAIMS MADE X OCCUR  |  |                                    |                                     | MED EXP (Any one person)                    | \$ 5,000     |  |
|        | X SIR: \$100,000   |  |                                    |                                     | PERSONAL & ADV INJURY                       | \$ 1,000,000 |  |
|        | GENERAL ACCRECATE LIMIT APPLIES DED                                  |  |                                    |                                     | GENERAL AGGREGATE                           | \$ 2,000,000 |  |
|        | GENERAL AGGREGATE LIMIT APPLIES PER PRO- POLICY JECT X LOC           |  |                                    |                                     | PRODUCTS - COMP/OP AGO                      | \$ 2,000,000 |  |
|        | AUTOMOBILE LIABILITY   |  |                                    |                                     |   |              |  |
|        | ANY AUTO   |  |                                    |                                     | COMBINED SINGLE LIMIT (Ea accident)         | \$           |  |
|        | ALL OWNED AUTOS  |  |                                    |                                     | BODILY INJURY                               | \$           |  |
|        | SCHEDULED AUTOS  |  |                                    |                                     | (Per person)                                |              |  |
|        | NON-OWNED AUTOS  |  |                                    |                                     | BODILY INJURY<br>(Per accident)             | \$           |  |
|        |  |  |                                    |                                     | PROPERTY DAMAGE<br>(Per accident)           | \$           |  |
|        | GARAGE LIABILITY   |  |                                    |                                     | AUTO ONLY - EA ACCIDENT                     | \$           |  |
|        | ANY AUTO   |  |                                    |                                     | OTHER THAN EA ACC                           | \$           |  |
|        |  |  |                                    |                                     | AUTO ONLY:                                  | \$           |  |
|        | EXCESS / UMBRELLA LIABILITY  |  |                                    |                                     | EACH OCCURRENCE                             | \$           |  |
|        | OCCUR CLAIMS MADE  |  |                                    |                                     | AGGREGATE                                   | \$           |  |
|        | DEDUCTIBLE   |  |                                    |                                     |   | \$           |  |
|        | RETENTION \$   |  |                                    |                                     |   | \$           |  |
| _      | WORKERS COMPENSATION AND   |  |                                    |                                     |   | \$           |  |
|        | EMPLOYERS' LIABILITY   |  |                                    |                                     | WC STATU- OTH-                              |              |  |
|        | ANY PROPRIETOR/PARTNER/EXECUTIVE Y / N OFFICER/MEMBER EXCLUDED?      |  |                                    |                                     | E.L. EACH ACCIDENT                          | \$           |  |
|        |  |  |                                    |                                     | E.L. DISEASE - EA EMPLOYEE                  | \$           |  |
|        | (Mandatory in NH) If yes, describe under<br>SPECIAL PROVISIONS below |  |                                    |                                     | E.L. DISEASE - POLICY LIMIT                 | \$           |  |
|        | OTHER  | 6793286  | 04/04/0040                         |                                     | - Eno C                                     | -            |  |
| -      | MEDICAL PROFESSIONAL CLAIMS-MADE COVERAGE                            | 0793200  | 01/01/2010                         | 01/01/2011                          | PER CLAIM<br>AGGREGATE                      | 1,000,000    |  |
|        | PROGRAM RETRO: 11/01/76  |  |                                    |                                     | AGGREGATE                                   | 3,000,000    |  |
|        | RIPTION OF OPERATIONS/LOCATIONS/VEHICLES                             | TVO USIONO ARREST  |                                    |                                     | i N   | ITT          |  |
|        |  | PERSONAL REPORT OF THE CASE OF | ENT/SPECIAL PROVISIONS             |                                     | A 2:  | V m          |  |
|        |  |  |                                    |                                     | S = +                                       | 0            |  |

| CERTIFIC | ATE H | OLDER |
|----------|-------|-------|
|----------|-------|-------|

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

Chri Kakul

|   | ACORD CERTIFIC  | CATE OF LIA  |   |   |  | 12     | TE (MM/DD/YY)<br>/18/2008 |  |
|---|---|--|---|---|--|--------|---------------------------|--|
| PRO   | ODUCER Marsh USA, Inc. 1166 Avenue of the Americas New York, NY 10036   |  | ONLY AND  | CONFERS N   | SUED AS A MATTER OF RIGHTS UPON THATE DOES NOT AMERITE POLICE BY THE POLICE OF T | HE CE  | ERTIFICATE<br>EXTEND OF   |  |
|   |   |  | INSURERS AFFORDING COVERAGE   |   |  |        | NAIC#                     |  |
| INS   | URED  |  | INSURER A: ACE American Insurance Company                             |   |  | 2266   | 7                         |  |
|   | PLANNED PARENTHOOD OF C<br>AN AFFILIATE OF PLANNED PA   | ONNECTICUT, INC.<br>RENTHOOD                           | INSURER B: Nationa  | INSURER B: National Union Fire Insurance Company  |  |        |                           |  |
|   | FEDERATION OF AMERICA, INC<br>345 WHITNEY AVENUE  |  | INSURER C:  |   |  |        |                           |  |
|   | NEW HAVEN, CT 06511   |  | INSURER D:  |   |  |        |                           |  |
|   |   |  | INSURER E:  |   |  |        |                           |  |
| CO  | OVERAGES  |  |   |   |  |        |                           |  |
|   | THE POLICIES OF INSURANCE LISTE<br>NOTWITHSTANDING ANY REQUIREMEN'<br>MAY BE ISSUED OR MAY PERTAIN, THE<br>CONDITIONS OF SUCH POLICIES. AGGRE | T, TERM OR CONDITION OF AN<br>INSURANCE AFFORDED BY TH | Y CONTRACT OR OTHER   | R DOCUMENT WI<br>HEREIN IS SUBJ   | TH RESPECT TO WHICH T  | HIS CE | ERTIFICATE                |  |
|   | INSRD TYPE OF INSURANCE   | POLICY NUMBER  | POLICY EFFECTIVE DATE (MM/DD/YY                                       | DATE (MM/DD/Y   |  | MITS   |                           |  |
| A   | GENERAL LIABILITY   | PMI G23857133-002                                      | 01/01/09  |   | EACH OCCURRENCE  | \$     | 2,000,0                   |  |
| 1   | X COMMERCIAL GENERAL LIABILITY  | FMI G23857133-002                                      | 01/01/09  | 01/01/10  | DAMAGE TO RENTED<br>PREMISES(Ea occurence)   | \$     | 100,0                     |  |
|   | CLAIMS MADE X OCCUR   |  |   |   | MED EXP (Any one person)   | \$     |                           |  |
|   | X SIR: \$100,000  |  |   |   | PERSONAL & ADV INJURY  | \$     | 2,000,0                   |  |
|   | GENERAL AGGREGATE LIMIT APPLIES PE  | R  |   |   | GENERAL AGGREGATE  | \$     | 4,000,0                   |  |
|   | GENERAL AGGREGATE LIMIT APPLIES PE  |  |   | 195   | PRODUCTS - COMP/OP AG  | 3\$    | 4,000,0                   |  |
|   | ANY AUTO  |  |   |   | COMBINED SINGLE LIMIT (Ea accident)  | \$     |                           |  |
|   | ALL OWNED AUTOS SCHEDULED AUTOS   |  |   |   | BODILY INJURY<br>(Per person)  | \$     |                           |  |
|   | HIRED AUTOS NON-OWNED AUTOS   |  |   |   | BODILY INJURY<br>(Per accident)  | \$     |                           |  |
|   |   |  |   | 76. 36  | PROPERTY DAMAGE<br>(Per accident)  | \$     |                           |  |
|   | GARAGE LIABILITY  |  |   |   | AUTO ONLY - EA ACCIDENT  | \$     |                           |  |
|   | ANY AUTO  |  |   |   | OTHER THAN EA ACC AGG  | \$     |                           |  |
| В   | EXCESS/UMBRELLA LIABILITY   | BE 17726658  | 01/01/09  | 01/01/10  | EACH OCCURRENCE  | \$     | 10,000,00                 |  |
|   | OCCUR CLAIMS MADE   |  |   |   | AGGREGATE  | \$     | 10,000,00                 |  |
|   | DEDUCTIBLE  |  |   |   | C 5  | \$     |                           |  |
|   | RETENTION \$  |  |   | 100   |  | \$     |                           |  |
| V   | WORKERS COMPENSATION AND  |  |   | -   | WC STATUS   OTH-   | \$     |                           |  |
| E   | EMPLOYERS' LIABILITY  |  |   |   | TORY LIMITS   FR   | •      |                           |  |
| A   | ANY PROPRIETOR/PARTNER/EXECUTIVE<br>OFFICER/MEMBER EXCLUDED?  |  |   |   | E.L. EACH ACCIDENT  E.L. DISEASE - EA EMPLOYER   | \$     | -                         |  |
| If  | If yes, describe under<br>SPECIAL PROVISIONS below  |  |   |   | E.L. DISEASE POLICY LIMIT  | -      |                           |  |
|   | OTHER   |  |   |   | DISEASE - FOLICI CIMIT   | -      |                           |  |
| C   | MEDICAL PROFESSIONAL<br>CLAIMS-MADE COVERAGE<br>PROGRAM RETRO: 11/01/76   | 6793286  | 01/01/09  | 01/01/10  | PER CLAIM-<br>AGGREGATE  |        | 1,000,00<br>3,000,00      |  |
| DESCR   | RIPTION OF OPERATIONS/LOCATIONS/VEHICLES  | EXCLUSIONS ADDED BY ENDORSE                            | MENT/SPECIAL PROVISIONS   |   |  |        |                           |  |
|   |   |  |   |   |  |        |                           |  |
| CERT  | TIFICATE HOLDER NYC-  | 003080013-17   | CANCELLATION  | 1 22 202  |  |        |                           |  |
| PLANNED PARENTHOOD OF CONNECTICUT, INC.<br>ATTN: LOUIS DENEGRE<br>345 WHITNEY AVENUE<br>NEW HAVEN, CT 06511 |   |  | BUT FAILURE TO DO  UPON THE  AUTHORIZED REPRESENTAT OF MARSH USA Inc. | BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND  UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.  AUTHORIZED REPRESENTATIVE OF MAISH USA INC. |  |        |                           |  |
|   |   |  | Chris Kakel   | _   |  | ~      |                           |  |

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

#### Board of Directors 2009-2010

#### Officers:

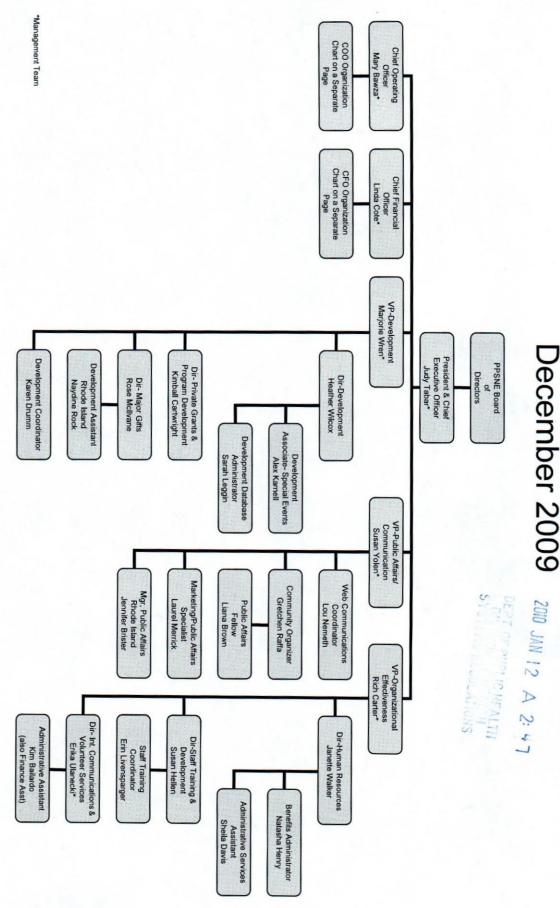
Kay Maxwell, Chair Deborah Freedman, Vice Chair Maria Cruz-Saco, Ph.D., Secretary Amelia Renkert-Thomas, J.D., Treasurer Sandra Arnold, Assistant Treasurer

#### **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

COLUMN 12 A 2: 4-

# Planned Parenthood of Southern New England



| On (date) _  | 2/5/2010   | , The (Town/City)  | Torrington         | Office of the                        | ne Fire Marshal                  |
|--------------|--|--|--------------------|--------------------------------------|----------------------------------|
| conducted    | an inspection of                                   | PLANNED PARE   | NTHOOD             |                                      |                                  |
| located at   | (address) 249                                      | Winsted Rd   |                    |                                      | in the                           |
| City/Town    | of Torring   | on   | _ to determine th  | ne degree of cor                     | mpliance with the                |
| fire safety  | requirements of                                    | Connecticut General  | Statutes Chapter   | 541 as authori                       | zed by                           |
| Section 29   | -305 of the statu                                  | tes. This facility was   | s evaluated as a ( | new/existing) _                      | Existing                         |
| (occupancy o | classification)]                                   | Business   |                    | as clas                              | sified                           |
| by the CC    | ONNECTICUT F                                       | TIRE SAFETY CODE   | . As a result of t | his inspection,                      | the following                    |
| condition    | s were found:                                      |  |                    | er 30 - 4 - 4                        |                                  |
|              |  |  |                    | to                                   | 2                                |
| II. A        | recommended.  At the time of insequirements of the | pection, no code vio<br>pection, conditions was<br>see codes. An accep-<br>tion). Certificate of a | vere discovered to | o be contrary to                     | the minimum                      |
|              |  | pection, conditions valuese codes. Certific  |                    |                                      | ·                                |
| tl<br>A      | his office is curre                                | eme hazard to publicently seeking an injurt<br>ourpose of of closing<br>formation). Certificat     | or restricting usa | ourt through ou<br>ge of this facili | r Town/City<br>ty to the public. |
| 11           | 110  | Ex   | pired              | 2/6/2011                             |                                  |
| W/           | 1  |  |                    |                                      | February 5, 2010                 |
| ire Marsha   | ıl   |  |                    |                                      | Date                             |
| City or Tow  | m: Torringt  | on   |                    |                                      |                                  |



# mai 130

#### STATE OF CONNECTICUT

| On (date)  | 1/13/2009 , The (Town/City) Torrington Office of the F   | ire Marshal      |  |  |  |
|------------|--|------------------|--|--|--|
| conducte   | ed an inspection of PLANNED PARENTHOOD   |                  |  |  |  |
| located a  | at (address) 249 Winsted Rd  | in the           |  |  |  |
| City/Tov   | wn of Torrington to determine the degree of compl  | iance with the   |  |  |  |
| fire safe  | ty requirements of Connecticut General Statutes Chapter 541 as authorized  | by               |  |  |  |
| Section    | 29-305 of the statutes. This facility was evaluated as a (new/existing)  | Existing         |  |  |  |
| (occupan   | cy classification) Business as classific   | ed               |  |  |  |
| by the     | CONNECTICUT FIRE SAFETY CODE. As a result of this inspection, the  | following        |  |  |  |
| conditi    | ons were found:  |                  |  |  |  |
|            |  |                  |  |  |  |
| <u>(1)</u> | At the time of inspection, no code violations were identified. Certificate recommended.  | e of approval    |  |  |  |
| 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. 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 of closing or restricting usage of this facility to the public. (See attached information). Certificate of approval NOT recommended. |                  |  |  |  |
|            | <u>Expired</u> 1/14/2010   |                  |  |  |  |
| DIM        | Edwill acto  | January 13, 2009 |  |  |  |
| Fire Mar   | shal   | Date             |  |  |  |

Torrington

City or Town:

copy



# FIRE MARSHAL ONLY





| On (date, | 1/13/2009 , The (Town/City)  | Torrington Office of the            | e Fire Marshal       |
|-----------|--|-------------------------------------|----------------------|
| conduct   | ted an inspection of PLANNED PARENT  | THOOD                               |                      |
| located   | at (address) 249 Winsted Rd  |                                     | in the               |
| City/To   | own of Torrington t  | to determine the degree of con      | npliance with the    |
| fire safe | ety requirements of Connecticut General St   | atutes Chapter 541 as authoriz      | zed by               |
| Section   | 29-305 of the statutes. This facility was e  | valuated as a (new/existing) _      | Existing             |
| (оссира   | ncy classification) Business   | as class                            | sified               |
| by the    | CONNECTICUT FIRE SAFETY CODE. A  | As a result of this inspection, the | he following         |
| condit    | tions were found:  | 44                                  | JAN 1 6 2009         |
|           |  | GEP<br>WV HE                        | T. OF PUBLIC HOLDING |
|           | At the time of inspection, no code violat recommended.   | ions were identified. Certific      | cate of approval     |
| 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 requirements of these codes. <b>Certifica</b>   |                                     |                      |
| IV.       | 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 of closing or restricting usage of this facility to the public. (See attached information). Certificate of approval NOT recommended. |                                     |                      |
|           | Ev   | pired 1/1//2010                     |                      |

Fire Marshal

City or Town:

Torrington

January 13, 2009

Date



### STATE OF CONNECTICUT

### DEPARTMENT OF PUBLIC HEALTH

### DIVISION OF HEALTH SYSTEMS REGULATION

To:

Administrator

Planned Parenthood of Conn., Inc.- Torrington

249 Winsted Road Torrington, CT 06790

From:

Rose McLellan

License and Applications Supervisor Facility License and Inspection Section

Date:

January 6, 2008

Subject:

March 2009 Annual Fire Marshal Certificate

In accordance with the Regulations of Connecticut State Agencies, a Fire Marshal's Certificate of Inspection must be submitted to the Department **annually**.

Enclosed is a Fire Marshal's Certificate of Inspection, which must be completed and returned to this office within thirty-(30) days. If for any reason the form cannot be submitted within this time frame, this office must be notified in writing of the reason for the delay. Additional forms may be xeroxed if necessary. Each completed Fire Marshal's Certificate of Inspection that is submitted must have an original signature.

Please do not hesitate to contact the Licensure Processing Unit at (860) 509-7444 if you have any questions.

RM/crj Enclosure





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

# 2008 YEAR

# FIRE MARSHAL ONLY



| On (date)1/10/2008 , The (Town/City) Torrington Office of the Fin  | re Marshal         |  |
|--|--------------------|--|
| conducted an inspection of PLANNED PARENTHOOD  |                    |  |
| located at (address) 249 Winsted Rd  | in the             |  |
| City/Town of to determine the degree of compliants   | ance 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)  | Existing           |  |
| (occupancy classification) Business as classifie   | dVE                |  |
| by the CONNECTICUT FIRE SAFETY CODE. As a result of this inspection, the f   | following 2008     |  |
| conditions were found:   | SALTH<br>EGULATION |  |
| At the time of inspection, no code violations were identified. Certificate recommended.  | of approval        |  |
| II. At the time of inspection, conditions were discovered to be contrary to the requirements of these codes. An acceptable plan of correction was submit attached information). Certificate of approval recommended.   |                    |  |
| III. At the time of inspection, conditions were discovered to be contrary to the requirements of these codes. Certificate of approval NOT recommen   |                    |  |
| 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 of closing or restricting usage of this facility to the public. (See attached information). Certificate of approval NOT recommended. |                    |  |
| <b>Expired</b> 1/10/2009   |                    |  |
| M Joseph Fichett   | January 10, 2008   |  |
| Fire Marshal   | Date               |  |
| City or Town: Torrington   |                    |  |



box/boxes that apply):

### STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

DIVISION OF HEALTH SYSTEMS REGULATION

### LICENSURE APPLICATION

[ ] INITIAL

RENEWAL

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

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

[ ] Assisted Living Services Agency [ ] Infirmary Operated by an Educational Institution [ ] Children's Hospital Maternity Home [ ] Chronic and Convalescent Nursing Home [ ] Maternity Hospital [ ] Chronic Disease Hospital Outpatient Clinic Family Planning Clinic [ ] Outpatient Dialysis Unit ] General Hospital Outpatient Surgical Facility [ ] Home Health Care Agency Residential Care Home ] Homemaker-Home Health Aide Agency [ ] Rest Home with Nursing Supervision [ ] Hospice [ ] Well Child Clinic [ ] Hospital for Mentally Ill Persons Please respond to all of the following questions: Facility "d/b/a" (doing business as) Name M. 249 Wusted Rd Torking
Business Address City State Same as above Mailing Address (if applicable)

State

Zip Code



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

FOR OFFICE USE ONLY CHECK # AMOUNT

DATE RCVE INITIALS

| Level of Care N/H   | Beds/<br>Hemodialysis Stations   | Bassinets (if applicable)  |
|---|----------------------------------|--|
| Level of Care / //  | riemodiarysis stations           | Bassinets (II applicable)  |
|   |                                  |  |
|   |                                  |  |
|   |                                  |  |
|   |                                  |  |
|   |                                  |  |
| 060263565   | 5                                |  |
| Federal Employer Identific  |                                  |  |
| rederal Employer Identific  | cation Number                    |  |
| Disclose the legal entity w   | hich owns/operates the facilit   | y. (Note: The license will be issued   |
| to this entity.)  | men evins, operates the facility | y. (110te. The heelise will be issued  |
| • •   | 0 . 2=                           | ,  |
| Planned Pare  | MHOOCH Of CI,                    | INC-JORRENGTON   |
| Licensee  | U                                |  |
| 0/10/10/10/10/  | 701                              | TNC-SORRING TOX<br>C7.06790 860-489<br>Telephone   |
| 299 Winster   | ROX TORRINGTON                   | , 61.06190 800-489   |
| Business Address  | City U Sta                       | fe Zip Code Telephone  |
|   |                                  |  |
| Mailing Address (if applic  | abla)                            |  |
| Maning Address (if applie   | able)                            |  |
| Is the above named legal e  | ntity a (please check the box    | which applies):  |
|   | , 4                              | The second secon |
| [ ] Individual/Sole propr   | ietor                            |  |
| [ ] General Partnership   |                                  |  |
| [ ] Limited Partnership   |                                  | ~  |
|   | nany                             | 6.2  |
| [ ] Limited Liability Con   | ipany                            |  |
| Limited Liability Con     Profit Corporation  |                                  |  |
| [ ] Limited Liability Con<br>[ ] Profit Corporation   |                                  |  |
| [ ] Limited Liability Con<br>[ ] Profit Corporation<br>[ ] Non-profit Corporation<br>[ ] Municipality   |                                  | JAN 100  |
| [ ] Limited Liability Con<br>[ ] Profit Corporation   |                                  | JAN 18   |
| [ ] Limited Liability Con<br>[ ] Profit Corporation<br>[ ] Non-profit Corporation<br>[ ] Municipality   |                                  | JAN 18 D   |
| [ ] Limited Liability Con [ ] Profit Corporation [ ] Non-profit Corporation [ ] Municipality [ ] Trust [ ] Other:   | on .                             | JAN 18 D 3:  |
| [ ] Limited Liability Con [ ] Profit Corporation [ ] Non-profit Corporation [ ] Municipality [ ] Trust [ ] Other:  Is the above named entity in the state of the | authorized by the Office of th   | e Secretary of State to transact   |
| [ ] Limited Liability Con [ ] Profit Corporation [ ] Non-profit Corporation [ ] Municipality [ ] Trust [ ] Other:  Is the above named entity in the state of the | authorized by the Office of th   | e Secretary of State to transact good Standing? [X] YES [ ] NO   |
| [ ] Limited Liability Con [ ] Profit Corporation [ ] Non-profit Corporation [ ] Municipality [ ] Trust [ ] Other:  Is the above named entity a business in the State of Co  | authorized by the Office of the  | lood Standing? [☐ YES [☐ NO  |
| [ ] Limited Liability Con [ ] Profit Corporation [ ] Non-profit Corporation [ ] Municipality [ ] Trust [ ] Other:  Is the above named entity abusiness in the State of Co   | authorized by the Office of the  | e Secretary of State to transact good Standing? [X] YES [ ] NO e number of the Agent for Service   |
| [ ] Limited Liability Con [ ] Profit Corporation [ ] Non-profit Corporation [ ] Municipality [ ] Trust [ ] Other:  Is the above named entity a business in the State of Co  | authorized by the Office of the  | lood Standing? [☐ YES [☐ NO  |

8. Attach an organizational chart which reflects the current ownership structure of the licensee and the licensee's relationship with the facility/agency. 19 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. 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. 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 ii. and all directors of the corporation. 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.) 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 a certificate of compliance issued by the Insurance Commissioner pursuant to Section B. 31-286 of the Conn. General Statutes: or

12. Ownership of Real Property

Planed Parenthood of CT, Inc. Torrington Center

Name

249 Winsted Rd Torrington, CT. 66790 860-489-5500

Business Address

City State Zip Code Telephone

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

C.

Insurance will be accepted.)

- 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 ALSA's, Homemaker Home Health and Home Health Agencies).
- 14. Affidavit of Owner:

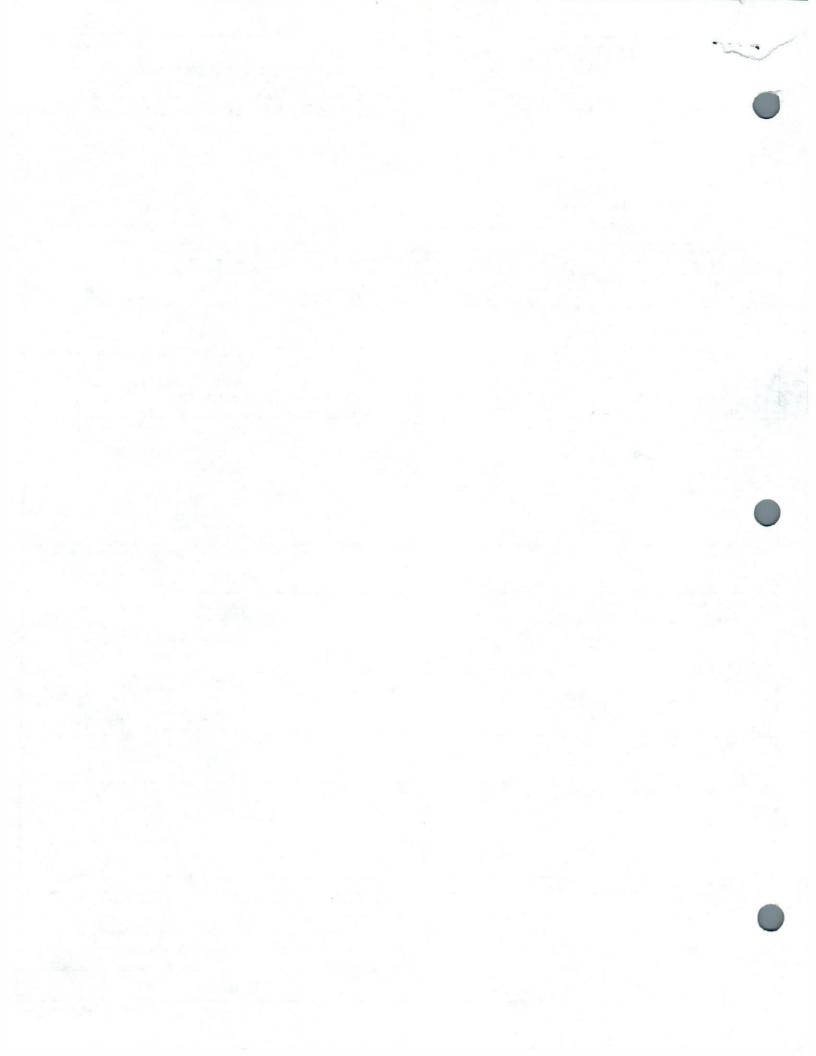
I attest that the information provided within this application is true and accurate and that any changes in the information submitted will be reported to the Department as required by law.

| Signature Jaba   | 1-10-06<br>Date Signed  |
|--|---|
| Check one as applicable:   |   |
| <ul> <li>[ ] Individual/Sole Proprietor</li> <li>[ ] General/Managing Partner</li> <li>[ ] President of Corporation</li> <li>[ ] Secretary of Corporation</li> <li>[ ] Municipal Officer</li> <li>[ ] Trustee</li> </ul> |   |
| State of Connecticut )   | 00 · 17 · 5   |
| County of New Haven )  | ss Jan 10 2006 4 4  |
| Personally appeared before me the above no made oath to the truth of the statements conquestions.  | amed Judy Tabar and attained in his/her answers to the foregoing  Sulf + Hellein        |
|  | Notary Public  Justice of the Peace  Town Clerk  Commissioner of the Superior Court [ ] |
| My Commission Expires: (If Notary Public)  |   |

| _                                      | ACORD CERTIFI   | CATE OF LIABILI  |   |   | AS A MATTER OF INFORM  | 1/20/2006        |  |
|--|---|--|---|---|--|------------------|--|
| CH                                     | WCT DOX 5042 866 N. Mai:  |  | ONLY AND<br>HOLDER T                        | CONFERS NO  | AS A MATTER OF INFORMA<br>RIGHTS UPON THE CERT<br>DOES NOT AMEND, EXTE<br>ORDED BY THE POLICIES                                    | TFICATE<br>ND OR |  |
| Wallingford. CT, 06492<br>203.678.0105 |   | INSURERS AFFORDING COVERAGE  |   |   |  |                  |  |
| SUR                                    | Planned Parenth   | ood of CT, Inc.  | INSURERA: CI                                | INSUMERA: CH Workers! Compensation Trust                                |  |                  |  |
|  |   |  | INSURER E:                                  | 14  | ( * 1 ( ) * · · ·  |                  |  |
|  | 345 Whitney Ave   | nue  | INSURER CL.                                 | 111   | SUKEU'S  |                  |  |
|  | New Haven, CT 0   | 6511   | INSURER D:                                  |   | CUBA   |                  |  |
|  |   |  | INSURER E                                   |   | 00.1   |                  |  |
| 234                                    | /ERAGES HE POLICIES OF INSURANCE LISTED BELG NY REQUIREMENT, TERM OR CONDITION ANY PERTAIN, THE INSURANCE AFFORDE! DUCIES AGGREGATE LINITS SHOWN MA | N OF ANY CONTRACT OR OTHER DOC<br>O BY THE POLICIES DESCRIBED HEREIN | INSTANT WITH RESPECT TO                     | WHICK THIS CERT   | ECATE MAY BE ISSUED OR   |                  |  |
| JR.                                    | TYPE OF INSURANCE   | POLICY NUMBER  | POLICY EFFECTIVE<br>DATE (NIMPODAY)         | DATE MANDOWY  | LIMTS  |                  |  |
|  | GENERAL LIABILITY   |  | -   | DAGE SHAPOOT 1)   |  | s                |  |
|  | COMMERCIAL GENERAL LIABILITY  |  |   |   | FIRE DAMASE (Any one fire)   | 1                |  |
|  | CLANS MADE DOCUM  |  |   |   | MED EXP (Any one person)   | ;                |  |
|  |   |  |   |   | PERSONAL & ADV INJURY  | \$               |  |
|  |   |  |   |   | GENERAL AGGREGATE  | 3                |  |
|  | GENT AGGREGATE LIMIT APPLIES PER  |  |   |   | PRODUCTS - COMPJOP AGG   | 3                |  |
| _                                      | POUCY PRO-  |  |   |   |  |                  |  |
|  | ANY AUTO  |  |   |   | COMBINED SINGLE LINIT<br>(Es acadent)  | •                |  |
|  | ALL OWNED AUTOS SCHEDULED AUTOS   |  |   |   | BOOLY HURY<br>For person)  | s                |  |
|  | HIRED AUTOS NON-OWINED AUTOS  |  |   |   | BOOILY BUURY<br>(Fer section!)   | \$               |  |
|  |   |  |   |   | PROPERTY DAMAGE<br>[Per septemb]   | \$               |  |
|  | GARAGELIABILITY   | get.   |   | 1   | AUTO DHLY - EA ACCIDENT  | \$               |  |
|  | ANY AUTO  | - 10 DE CENT TO  |   |   | OTHER THAN EA ACC  | 1                |  |
| -                                      | EXCERS LIABILITY  |  |   |   | ***  | 3                |  |
|  | OCCUR CLAMS MADE  |  |   |   | EACH OCCURRENCE  | :                |  |
|  |   |  |   |   | AGGREGATE  | \$               |  |
|  | DEDUCTIBLE  |  |   |   |  | 1                |  |
|  | RETENTION S   |  |   |   |  | \$               |  |
|  | WORKERS COMPENSATION AND  | <u> </u>   |   | <del> </del>  | X WCSTATU CTHA   | 1                |  |
|  | EMPLOYERS LIABILITY   | WCP 394  | 1/01/06                                     | 1/01/07   |  | 12,500,000       |  |
| A                                      |   |  | ,,,,,,,,                                    | 2,02,0,   | E.L. EACH ACCIDENT   | \$2,500,000      |  |
|  |   |  |   |   | E.L. DISEASE - EA EMPLOYEE  EL. DISEASE - POLICY LINIT   | \$2,500,000      |  |
|  | OTHER   |  |   |   | EC. DISDOSE - FOLIOI CAII  | g/ages           |  |
|  |   |  |   |   |  | P II I           |  |
|  |   |  |   |   | - T  | Epolis .         |  |
| DES                                    | ICREPTION OF OPERATIONS LOCATIONS VEHICLES  | Perclysions added by Endorsoment/Specu                               | L Prongens                                  |   | 7  | Ö                |  |
| CE                                     | ERTIFICATE HOLDER   | DOITIONAL INSURED; INSURER LETTER:                                   | CANCELLA                                    | TION  |  |                  |  |
|  | Planned Parent<br>249 Winsted Ro<br>Torrington, CT  |  | DATE THEREO<br>HOTICE TO TH<br>MIPCISE NO D | F, THE ISSUING INSURE<br>E CERTIFICATE HOLDER<br>BLICATION OR LIABILITY | ED POLICES BE CANCELLED BEFORE T<br>R WELL ENDEANOR TO MAE<br>NAMED TO THE LEFT, BUT FALLIRE TO<br>OF MY KIND UPON THE INSURER, IT | 10 DAYS WRITTE   |  |
|  | siconomico  |  | AUTHORIZED RI                               | Vallan  | 7. Sha   | lee              |  |

ACORD 25-S (7/97)

### DATE (MWDD/YY) ACORD ... CERTIFICATE OF LIABILITY INSURANCE 02/24/2005 THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION PRODUCER ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE WWCT HOLDER, THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. Box 5042 866 N. Main St. Ext. Wallingford. CT, 06492 INSURERS AFFORDING COVERAGE 203.678.0105 Planned Parenthood of CT, Inc. CH Workers' Compensation Trust INSURED INSURER A INSURER B: 345 Whitney Avenue INSURER C New Haven, CT 06511 INSURER D: INSURER E: COVERAGES 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, AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS. POLICY EFFECTIVE POLICY EXPIRATION TYPE OF INSURANCE POLICY NUMBER DATE (MWDD/YY) DATE (MWDD/YY) EACH OCCURRENCE \$ GENERAL LIABILITY FIRE DAMAGE (Any one fire) COMMERCIAL GENERAL LIABILITY CLAIMS MADE OCCUR MED EXP (Any one person) PERSONAL & ADV INJURY \$ GENERAL AGGREGATE \$ PRODUCTS - COMP/OP AGG \$ GEN'L AGGREGATE LIMIT APPLIES PER: POLICY AUTOMOBILE LIABILITY COMBINED SINGLE LIMIT (Ea accident) ALL OWNED AUTOS BODILY INJURY \$ SCHEDULED AUTOS HIRED AUTOS **BODILY INJURY** NON-OWNED AUTOS PROPERTY DAMAGE AUTO ONLY - EA ACCIDENT GARAGE LIABILITY S ANY AUTO EA ACC OTHER THAN AUTO ONLY: s AGG EACH OCCURRENCE EXCESS LIABILITY \$ \$ OCCUR CLAIMS MADE AGGREGATE \$ DEDUCTIBLE \$ RETENTION X WC STATU-TORY LIMITS WORKERS COMPENSATION AND **EMPLOYERS' LIABILITY** WCP 394 1/01/05 1/01/06 \$2,500,000 E.L. EACH ACCIDENT \$2,500,000 A E.L. DISEASE - EA EMPLOYEE \$2,500,000 E.L. DISEASE - POLICY LIMIT OTHER DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENT/SPECIAL PROVISIONS CERTIFICATE HOLDER CANCELLATION ADDITIONAL INSURED; INSURER LETTER: SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION Planned Parenthood of CT, Inc. 10 DAYS WRITTEN DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 249 Winsted Road NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL Torrington, CT 06790 IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES. AUTHORIZED REPRESENTATIVE indir. ACORD 25-S (7/97) **© ACORD CORPORATION 1988**



### **MARSH**

### CERTIFICATE OF INSURANCE

NYC-001272219-06

PRODUCER

INSURED

Marsh USA Inc. 1166 Avenue of the Americas New York, NY 10036-2774

345 WHITNEY AVENUE

NEW HAVEN, CT 06511

PLANNED PARENTHOOD OF CONNECTICUT, INC. AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER OTHER THAN THOSE PROVIDED IN THE POLICY. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES DESCRIBED HEREIN.

| COMPANIES | <b>AFFORDING</b> | COVERAGE |
|-----------|------------------|----------|
|-----------|------------------|----------|

COMPANY

A ACE AMERICAN INSURANCE COMPANY

COMPANY

B NATIONAL UNION FIRE INS. CO.

COMPANY

C N/A

COMPANY

D N/A

### COVERAGES

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

| CO | TYPE OF INSURANCE                             | POLICY NUMBER | POLICY EFFECTIVE<br>DATE (MM/DD/YY) | POLICY EXPIRATION<br>DATE (MM/DD/YY) | Ш                                       | MITS                   |
|----|---|---------------|-------------------------------------|--------------------------------------|---|------------------------|
| A  | GENERAL LIABILITY                             | XSLG22903809  | 12/31/05                            | 12/31/06                             | GENERAL AGGREGATE                       | \$ 2,000,000           |
|    | X COMMERCIAL GENERAL LIABILITY                |               |                                     |                                      | PRODUCTS - COMP/OP AGG                  | \$ 1,000,000           |
|    | CLAIMS MADE X OCCUR                           |               |                                     |                                      | PERSONAL & ADV INJURY                   | \$ 1,000,000           |
|    | OWNER'S & CONTRACTOR'S PROT                   |               |                                     |                                      | EACH OCCURRENCE                         | \$ 1,000,000           |
|    | X SIR: \$100,000                              |               |                                     |                                      | FIRE DAMAGE (Any one fire)              | \$ 100,000             |
|    |   |               |                                     |                                      | MED EXP (Any one person)                | \$                     |
|    | ANY AUTO ALL OWNED AUTOS                      |               |                                     |                                      | COMBINED SINGLE LIMIT                   | \$                     |
|    | SCHEDULED AUTOS                               |               |                                     |                                      | BODILY INJURY<br>(Per person)           | \$77                   |
|    | HIRED AUTOS NON-OWNED AUTOS                   |               |                                     |                                      | BODILY INJURY<br>(Per accident)         | \$                     |
|    |   |               |                                     |                                      | PROPERTY DAMAGE                         | \$                     |
|    | GARAGE LIABILITY                              |               |                                     |                                      | AUTO ONLY - EA ACCIDENT                 | \$                     |
|    | ANY AUTO                                      |               |                                     |                                      | OTHER THAN AUTO ONLY:                   | ¥                      |
|    |   |               |                                     |                                      | EACH ACCIDENT                           | \$                     |
|    |   |               |                                     |                                      | AGGREGATE                               | \$                     |
|    | EXCESS LIABILITY                              |               |                                     | any any                              | EACH OCCURRENCE                         | \$                     |
|    | UMBRELLA FORM                                 |               |                                     |                                      | AGGREGATE                               | \$                     |
|    | OTHER THAN UMBRELLA FORM                      |               |                                     |                                      | 1 | \$                     |
|    | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY |               |                                     |                                      | WC STATU-<br>TORY LIMITS ER             |                        |
|    |   |               |                                     |                                      | EL EACH ACCIDENT                        | \$                     |
|    | THE PROPRIETOR/ PARTNERS/EXECUTIVE            |               |                                     |                                      | EL DISEASE-POLICY LIMIT                 | \$                     |
|    | OFFICERS ARE: EXCL                            |               |                                     |                                      | EL DISEASE-EACH EMPLOYEE                | \$                     |
| 2  | MEDICAL DECEMBER                              | 6793286       | 12/31/05                            | 12/31/06                             | PER CLAIM<br>AGGREGATE                  | 1,000,000<br>3,000,000 |

### CERTIFICATE HOLDER

PLANNED PARENTHOOD OF CONNECTICUT, INC. ATTN: LOUIS DENEGRE 345 WHITNEY AVENUE NEW HAVEN, CT 06511

### CANCELLATION

MARSH USA INC.

BY: Chris Kakel

Chri Kakel

MM1(3/02)

VALID AS OF: 12/21/05

MARSH USA INC. 1166 AVENUE OF THE AMERICAS NEW YORK, NY 10036-2774

PLANNED PARENTHOOD OF CONNECTICUT, INC.
ATTN: LOUIS DENEGRE
345 WHITNEY AVE
NEW HAVEN CT 06511-2348

100



### STATE OF CONNECTICUT

### DEPARTMENT OF PUBLIC HEALTH

### DIVISION OF HEALTH SYSTEMS REGULATION

### FORM 3

| FACI             | LITY/AGENCY NAME: Planned Parenthood of CT, Inc Torring   |
|------------------|---|
| Form<br>a corp   | 3 must be completed if the facility/agency or Real Property Owner is owned/operated by poration (profit or non-profit). Please copy additional sheets if necessary.   |
| inform<br>two la | ach stockholder with a 10% or greater ownership interest in the Licensee, provide the nation requested below. If no owner owns 10% or more of the total shares, please indicate the argest stockholders. Please complete a separate form for each legal entity listed below that an individual. |
| This i           | nformation is for: \(\sum_{\text{Licensee}}\)   |
|                  | Real Property Owner   |
|                  | * see attacked list of board of directors   |
| 1.               | Name:   |
|                  | Address:  |
|                  | l'elephone:   |
|                  | Stockholder's percentage of ownership:  |
|                  | Stockholder's occupation with the owner:  |
| 2.               | Name:   |
|                  | Address:  |
|                  | Telephone:  Stockholder's percentage of ownership:  Stockholder's accumation with the owner.  |
|                  | Stockholder's percentage of ownership:  |
|                  | Stockholder's occupation with the owner:  |
|                  |   |
| 3.               | Name:   |
|                  | Address: Telephone: Stockholder's percentage of ownership:  |
|                  | 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:

### Planned Parenthood of Connecticut, Inc. Judy Tabar, President and CEO

### Board of Directors 2005-2006

### **Fernando Betancourt**

345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### Maria Cruz-Saco

345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### **Monica Debiak**

345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### Ana De Santiago Ayón

345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### **Deborah Freedman**

345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### Jennifer B. Gallagher

345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### Christina N. Gianopulos

345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### Sue Hessel

345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### **Barry Kramer**

Board Treasurer 345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### Maria LaSala

345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### Dana McGee

Board Secretary 345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### Jewel Mullen

345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### Kim-Thu Pham

Board Vice Chair 345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### Ellen J. Schapps Richman

345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### Nancy Rosen

Assistant Treasurer 345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### Rachel Sheppard Rubin

345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### Robert Scalettar

345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### Seymour M. Smith

Board Chair 345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### Cyndi Billian Stern

345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

### Richard Sugarman

345 Whitney Avenue New Haven, CT 06511 (203) 865-5158

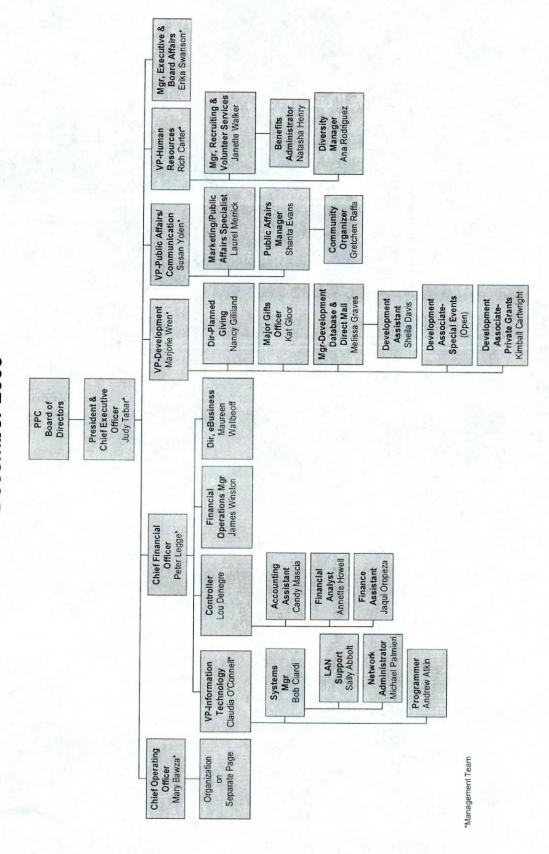
### **Calvin Warren**

345 Whitney Avenue New Haven, CT 06511 (203) 865-5158



# Planned Parenthood of Connecticut December 2005

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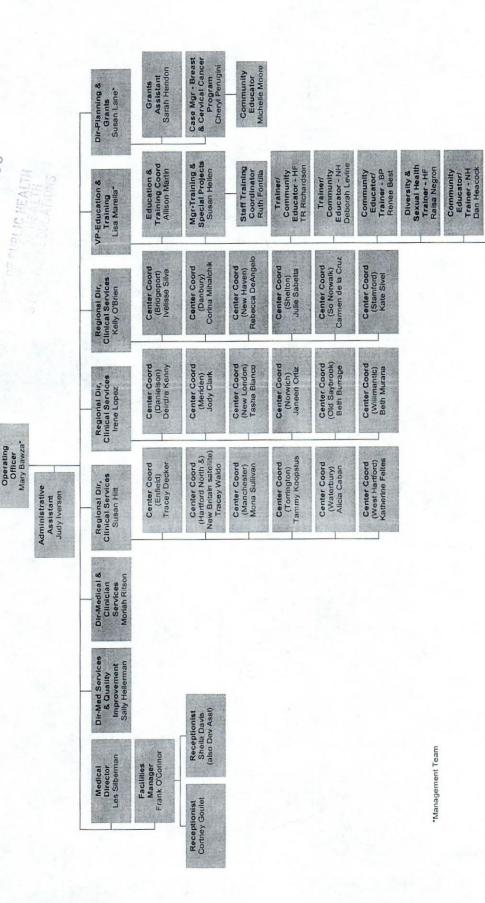


# Chief Operating Officer December 2005

Chief Operating Officer Mary Bawza\*

2006 JAN 18 P 3: 58

RECEIVED





Community Educator/ Trainer - WL Megan Andelloux



### STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

### DIVISION OF HEALTH SYSTEMS REGULATION

### LICENSURE APPLICATION - ADDITIONAL INFORMATION REQUIRED

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

| Pleas | se respond to all of the following questions:  |
|-------|--|
| 1.    | Planned Parenthood of CT, Inc., To Reington Center<br>Facility "d/b/a" (doing business as) Name  |
|       | 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.    | Lester Silberman, MD.  |
| 4.    | Administrator (Your name needs to appear as it is shown on your Professional License).   |
|       | Medical Director  (Your name needs to appear as it is shown on your Professional License).   |
| 5.    | Hours of Operation: M-11:00-6:30, T 8:30-4:00 W-CIOSED, TH 11:00-6:30, F 8:30  |
| 6.    | Please list the facility's fax number: $8604961754$ . Has this number changed since your last application? [ ] YES [ $\times$ ] NO   |
| 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. |
|       | Annua Konstus 1-10-06  |

Signature of Administrator Date Signed

Center Coordinator.

\* please Note on Tues Jan 31st the office will be closing for the day of 11:30 am for the staff to attend a training. Thank you.



January 13, 2006

Attn: Rose McLellan, License and Applications Supervisor State of Connecticut
Department of Public Health
410 Capitol Avenue – MS # 12 HFL
PO Box 340308
Hartford, CT. 06134

Re: License Renewal Application - Torrington Center

anny F. Koopstus

Dear Ms. McLellan:

Enclosed you will find the License Renewal Application for our center in Torrington. Please note that on Tuesday January 31<sup>st</sup> our office will be closing at 11:30 am to enable the staff to attend a required training. Also the certificate of liability insurance enclosed is last years copy. We are awaiting the current copy from our insurance company. When it arrives, I will forward it to you.

If there are any problems or questions with regard to this renewal, please give me a call. Thanks for your attention.

Sincerely,

Tammy J. Koopstus Center Coordinator



| On (date)1/           | 13/2006 , The (Town/City) Torrington Office of the F   | ire Marshal      |  |  |
|-----------------------|--|------------------|--|--|
| conducted an insp     | pection of PLANNED PARENTHOOD  |                  |  |  |
| located at (address)  | 249 Winsted Rd   | in the           |  |  |
| City/Town of          | <b>Torrington</b> to determine the degree of comple  | liance with the  |  |  |
| fire safety require   | ements of Connecticut General Statutes Chapter 541 as authorized   | l by             |  |  |
| Section 29-305 o      | of the statutes. This facility was evaluated as a (new/existing)   | Existing         |  |  |
| (occupancy classifica | as classifi  | ed               |  |  |
| by the CONNEC         | CTICUT FIRE SAFETY CODE. As a result of this inspection, the   | following        |  |  |
| conditions were       | found:   |                  |  |  |
|                       |  |                  |  |  |
|                       | time of inspection, no code violations were identified. Certificat   | e of approval    |  |  |
| require               | ime of inspection, conditions were discovered to be contrary to the ments of these codes. An acceptable plan of correction was submed information). Certificate of approval recommended.   | acolina 2 2 2    |  |  |
|                       | time of inspection, conditions were discovered to be contrary to the ments of these codes. <b>Certificate of approval</b> NOT recomme  | ne minimum, m    |  |  |
| this of               | 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 of closing or restricting usage of this facility to the public. (See attached information). Certificate of approval NOT recommended. |                  |  |  |
| 1                     | <b>Expired</b> 1/14/2007   |                  |  |  |
| 1/1/1                 |  | January 13, 2006 |  |  |
| Fire Marshal          |  | Date             |  |  |
| City or Town:         | Torrington   |                  |  |  |