STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0038

Family Planning

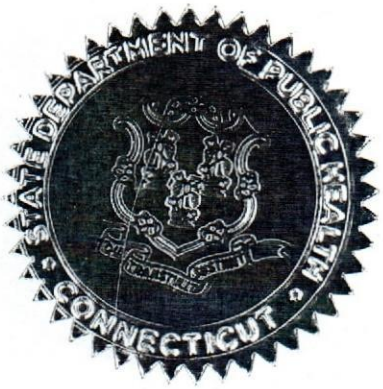
In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:
Connecticut Public Health Code, Section 19-13-D54:

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

Planned Parenthood of Southern New England Inc. is located at 100 Grand Street, New Britain, CT06051

This license expires **December 31, 2020** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2017



Raul Pino, MD, MPH
Commissioner

STATE OF CONNECTICUT

Department of Public Health

LICENSE

License No. 0038

Outpatient Clinic

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

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

Planned Parenthood Of Southern New England, Inc. is located at 100 Grand Street, New Britain, CT 06051.

This license expires **December 31, 2013** and may be revoked for cause at any time.

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

J Robert Galvin MD, MPH, MBA

J. Robert Galvin, MD, MPH, MBA, Commissioner

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

FACILITY LICENSE & INVESTIGATIONS SECTION

LICENSURE APPLICATION

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

NOTICE: The State of Connecticut values the quality of care provide to all nursing home residents. Please know that any nursing home licensee, owner or officer, including, but not limited to , a director, trustee, limited partner, managing partner, general partner or any person having at least 10 per cent (10%) ownership interest in the nursing home or the entity that owns the nursing, and any administrator, assistant administrator, medical director, director of nursing or assistant director of nursing, may be subject to civil and criminal liability, as well as administrative sanction under applicable federal and state law, for the abuse or neglect of a resident of the nursing home perpetrated by an employee of the nursing home.

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

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

100 Grand St., New Britain, CT, 06051
Business Address City State Zip Code Telephone

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

2. 06-0263565
Federal Employer Identification Number

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

An Equal Opportunity Employer

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

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

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

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

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

Planned Parenthood of Southern New England
Licensee

345 Whitney Avenue, New Haven, CT 06511 203-865-5158
Business Address City State Zip Code Telephone

(Same as above)
Mailing Address (if applicable)

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

[ ] Individual/Sole proprietor
[ ] General Partnership
[ ] Limited Partnership
[ ] Limited Liability Company
[ ] Other: _____
[X] Non-profit Corporation
[ ] Municipality
[ ] Trust
[ ] Profit Corporation

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

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

Judy Tabar 345 Whitney Avenue, New Haven, CT 06511 203-826-5158

Name Address Telephone

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

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

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

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

   C. If the Licensee is a **corporation (profit or non-profit),** complete Form 3 (attached) for the Licensee. Complete a separate Form 3 for each additional corporate entity having 10% or greater ownership interest in the Licensee.
      i. If the corporation is incorporated in a state other than Connecticut, please attach a Certificate of Good Standing from the Secretary of State of the state of incorporation.
      ii. Attach a list including the name, address and telephone number of all officers and all directors of the corporation.

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

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

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

****

FOR OFFICE USE ONLY

CHECK # _____ AMOUNT $_____

DATE RECEIVED _____ INITIALS _____

12. Ownership of Real Property

Hospital of Central Connecticut at New Britain General
Name

100 Grand St., New Britain, CT, 06052 860-224-5011
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: Hospitals must have a separate Fire Marshal's Certificate of Inspection completed for each building on the hospital's campus and each satellite listed on the hospital's license. Additional forms may be copied if necessary. (Not applicable for Homemaker Home Health and Home Health Agencies).**

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

Judy Tabar
Signature

1/3/17
Date Signed

Check one as applicable:

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

State of Connecticut)
County of New Haven) ss January 2017

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

Sally A Hellerman

Notary Public	[✓]
Justice of the Peace	[ ]
Town Clerk	[ ]
Commissioner of the Superior Court	[ ]

My Commission Expires:
(If Notary Public)

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

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

STATE OF CONNECTICUT
INSPECTION CERTIFICATE

On **December 14, 2016** the New Britain Office of the Fire Marshal conducted an inspection of **Hospital of Central Connecticut at New Britain General** located at **100 Grand Street** in the **City of New Britain** to determine the degree of compliance with the fire safety requirements of Connecticut General Statutes Chapter 541 as authorized by Section 29-305 of the statutes. This facility was evaluated as an **Existing Health Care** as classified by the *CONNECTICUT STATE FIRE SAFETY CODE*. As a result of this inspection, the following conditions were found:

I. ☒ At the time of inspection, no code violations were identified. **Certificate of approval recommended.**

II. ☐ At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. An acceptable plan of correction was submitted. (*See attached information*) **Certificate of approval recommended.**

III. ☐ At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. No approved plan of correction was submitted. (*See attached information*) **Certificate of approval NOT recommended.**

IV. ☐ Based on the extreme hazard to public safety discovered at the time of this inspection, this office is currently seeking an injunction from the court through our Town/City Attorney for the purpose of closing or restricting usage of this facility by the public. (*See attached information*) **Certificate of approval NOT recommended**

Fire Marshal

December 19, 2016
Date

City or Town: **New Britain**

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

FACILITY LICENSING & INVESTIGATIONS SECTION

LICENSURE APPLICATION - ADDITIONAL INFORMATION REQUIRED

OUTPATIENT CLINICS, WELL CHILD CLINICS AND FAMILY PLANNING CLINICS

Please respond to all of the following questions:

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

160 Grand St., New Britain, CT 06051
Business Address City State Zip Code Telephone

2. Is this program a School Based Health Center? [ ] Yes [X] No

3. Check the appropriate box/boxes describing the services to be provided by the clinic:

[ ] Primary Care	[X] Family Planning
[ ] Well Child Clinic	[ ] Abortion Procedures
[ ] Dental	[ ] Mental Health Services

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

4. Samantha Dobson
Administrator (Your name needs to appear as it is shown on your Professional License).

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

6. Days & Hours of Operation: T: 4:30pm-7:30pm TR: 4:30pm-7:30pm
You MUST notify this agency when ANY change to the noted day/time changes. We accept email and fax.

7 Please provide a list of services that will be provided. If this is for the addition of services, please also provide the resume of the person(s) who will be providing the services.

8. Business Fax Number: (203) 639-5085

9. Business Email Address: Samantha.Dobson@ppsne.org
Mandatory for Emergency Preparedness purposes

10. Business Cell Phone Number with Texting capabilities of the Administrator: (203) 305-6087
Mandatory for Emergency Preparedness purposes

CERTIFICATE OF LIABILITY INSURANCE

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

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

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

PRODUCER
Marsh USA, Inc.
1166 Avenue of the Americas
New York, NY 10036
Attn: healthcare.accountscss@marsh.com Fax: 212-948-1307

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

CONTACT NAME:
PHONE (A/C, No, Ext): **FAX (A/C, No):**
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : N/A	N/A
INSURER B : ACE American Insurance Company	22667
INSURER C : N/A	N/A
INSURER D :	
INSURER E :	
INSURER F :	

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

COVERAGES **CERTIFICATE NUMBER:** NYC-007090691-05 **REVISION NUMBER:** 2

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

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

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

CERTIFICATE HOLDER

PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC.
RAND STREET
NEW BRITAIN, CT 06052

CANCELLATION

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

AUTHORIZED REPRESENTATIVE of Marsh USA Inc.
Ricki Fitzsimmons

CERTIFICATE OF LIABILITY INSURANCE

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

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

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

PRODUCER Marsh USA, Inc. 1166 Avenue of the Americas New York, NY 10036 Attn: healthcare.accountscss@marsh.com Fax: 212-948-1307 109210-NIP-CAS-17-18 NEW,C PL	**CONTACT NAME:** **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:**
INSURED PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC., AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. 345 WHITNEY AVENUE NEW HAVEN, CT 06511	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** N/A — N/A **INSURER B :** National Union Fire Ins. Co. of Pittsburgh, PA — 19445 **INSURER C :** **INSURER D :** **INSURER E :** **INSURER F :**

COVERAGES **CERTIFICATE NUMBER:** NYC-007478051-03 **REVISION NUMBER:** 2

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

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

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

EVIDENCE OF COVERAGE FOR HEALTH CENTER

CERTIFICATE HOLDER

PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND
1000 GRAND STREET
NEW BRITAIN, CT 06052

CANCELLATION

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

AUTHORIZED REPRESENTATIVE of Marsh USA Inc.

Ricki Fitzsimmons

CERTIFICATE OF LIABILITY INSURANCE

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

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

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

PRODUCER Marsh USA, Inc. 1166 Avenue of the Americas New York, NY 10036 Attn: healthcare.accountscss@marsh.com Fax: 212-948-1307 109210-NIP-CAS-17-18 NEW,C GLPL	**CONTACT NAME:** **PHONE (A/C, No, Ext):** **FAX (A/C, No):** **E-MAIL ADDRESS:**
INSURED PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC. AN AFFILIATE OF PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. 345 WHITNEY AVENUE NEW HAVEN, CT 06511	**INSURER(S) AFFORDING COVERAGE** — **NAIC #** **INSURER A :** New Hampshire Insurance Company — 23841 **INSURER B :** National Union Fire Ins. Co. of Pittsburgh, PA — 19445 **INSURER C :** **INSURER D :** **INSURER E :** **INSURER F :**

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

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

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

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

CERTIFICATE HOLDER

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

CANCELLATION

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

AUTHORIZED REPRESENTATIVE of Marsh USA Inc.

Ricki Fitzsimmons

CERTIFICATE OF LIABILITY INSURANCE

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

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

PRODUCER
Marsh USA, Inc.
1166 Avenue of the Americas
New York, NY 10036
Attn: healthcare.accountscss@marsh.com Fax: 212-948-1307

109210-NIP-CAS-17-18 NEW,C GL

CONTACT NAME:
PHONE (A/C, No, Ext): **FAX (A/C, No):**
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : New Hampshire Insurance Company	23841
INSURER B : N/A	N/A
INSURER C :	
INSURER D :	
INSURER E :	
INSURER F :	

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

COVERAGES **CERTIFICATE NUMBER:** NYC-007479796-31 **REVISION NUMBER:** 2

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

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

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

CERTIFICATE HOLDER

NEW BRITAIN GENERAL HOSPITAL
ATTN: NANCY KROEBER
100 GRAND STREET
NEW BRITAIN, CT 06050

CANCELLATION

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

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Ricki Fitzsimmons

2013

RENEWAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

FACILITY LICENSE & INVESTIGATIONS SECTION

LICENSURE APPLICATION

[ ] INITIAL [✓] RENEWAL [ ] CHANGE OF OWNERSHIP

NOTICE: Any nursing home licensee, owner or officer, including, but not limited to, a director, trustee, limited partner, managing partner, general partner or any person having at least 10 per cent (10%) ownership interest, and any administrator, assistant administrator, medical director, director of nursing or assistant director of nursing, may be subject to criminal liability, in addition to civil and administrative sanctions under federal and state law, for the abuse or neglect of a resident of the nursing home perpetrated by an employee of the nursing home.

NOTE: A separate application must be completed for each licensed level of care, weather 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
[ ] Children's Hospital
[ ] Chronic and Convalescent Nursing Home
[ ] Chronic Disease Hospital
[✓] Family Planning Clinic
[ ] General Hospital
[ ] Home Health Care Agency
[ ] Homemaker-Home Health Aide Agency
[ ] Hospice
[ ] Hospital for Mentally Ill Persons
[ ] Mental Health Psychiatric OutPat.
[ ] Mental Health Intermediate Tmt.
[ ] Substance Abuse & Dependence
[ ] Infirmary Operated by an Educational Institution
[ ] Maternity Home
[ ] Maternity Hospital
[ ] Outpatient Clinic/Primary Care
[ ] Outpatient Dialysis Unit
[ ] Outpatient Surgical Facility
[ ] Residential Care Home
[ ] Rest Home with Nursing Supervision
[ ] In-Patient Hospice Unit
[ ] Well Child Clinic
[ ] Mental Health Day Treatment
[ ] Mental Health Community Residence
[ ] Mental Health Residential Living

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

An Equal Opportunity Employer

Please respond to all of the following questions:

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

100 Grand Street New Britain CT 06052 (203)238-0542
Business Address City State Zip Code Telephone

same
Mailing Address (if applicable) City State Zip Code

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

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

3. 060263510 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

345 Whitney Ave New Haven CT 06511 (203)865-5158
Business Address City State Zip Code Telephone

same
Mailing Address (if applicable)

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

[ ] Individual/Sole proprietor
[ ] General Partnership
[ ] Limited Partnership
[ ] Limited Liability Company
[ ] Other: _____
[✓] Non-profit Corporation
[ ] Municipality
[ ] Trust
[ ] Profit Corporation

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

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

Judy Tabar 345 Whitney Ave New Haven, CT 06511 (203) 865-5158

Name Address Telephone

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

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

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

   B. If the Licensee is a **trust,** complete Form 2 (attached) for the Licensee.

      i. Attach a list including the name, address and telephone number of all trustees.

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

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

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

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

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

12. Ownership of Real Property

Hospital of Central Connecticut

Name

100 Grand Street New Britain CT 06052

Business Address City State Zip Code Telephone

****

FOR OFFICE USE ONLY

CHECK # _____ AMOUNT $_____

DATE RECEIVED _____ INITIALS _____

****

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

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

Judy Tabar — Signature

11/8/13 — Date Signed

Check one as applicable:

[ ] Individual/Sole Proprietor
[ ] General/Managing Partner
[X] President of Corporation
[ ] Secretary of Corporation
[ ] Municipal Officer
[ ] Trustee

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State of Connecticut)

County of New Haven) ss 4/5 20 13

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

Sally A Heilerman

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

My Commission Expires:
(If Notary Public)

Sally Heilerman
Notary Public-Connecticut
My Commission Expires
December 31, 2016

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 12/21/2012

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

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

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

CONTACT NAME:
PHONE (A/C, No, Ext):
FAX (A/C, No):
E-MAIL ADDRESS:

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Markel Insurance Company	38970
INSURER B : N/A	N/A
INSURER C : National Union Fire Ins. Co. of Pittsburgh, PA	19445
INSURER D :	
INSURER E :	
INSURER F :	

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

COVERAGES **CERTIFICATE NUMBER:** NYC-005757681-25 **REVISION NUMBER:**

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

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	**GENERAL LIABILITY**			3C40797	01/01/2013	01/01/2014	EACH OCCURRENCE	$ 1,000,000
	X COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED 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 AGGREGATE	$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PRODUCTS - COMP/OP AGG	$ 2,000,000
	POLICY PRO-JECT X LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						WC STATU-TORY LIMITS OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) N/A						E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
C	MEDICAL PROFESSIONAL			6793286	01/01/2013	01/01/2014	PER CLAIM	$1,000,000
	CLAIMS-MADE COVERAGE			Program Retro Date: 11/1/76			AGGREGATE	$3,000,000

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

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CERTIFICATE HOLDER

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

CANCELLATION

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

AUTHORIZED REPRESENTATIVE
of Marsh USA Inc.
Ricki Fitzsimmons

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 4/11/2013

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

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

PRODUCER	CONTACT NAME: Lori Toussaint
Lindquist Insurance Associates 24 Lexington St New Britain CT 06052	PHONE (A/C, No, Ext): (860) 224-2413 FAX (A/C, No): (860) 225-8917 E-MAIL ADDRESS: Lori.Tousssaint@lindquist-insurance.com

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
Planned Parenthood Of So. New England, Inc 345 Whitney Ave New Haven CT 06511	INSURER A: Trust Workers Compensation	
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** CL1341100728 **REVISION NUMBER:**

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

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	GENERAL LIABILITY						EACH OCCURRENCE	$
	COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
	CLAIMS-MADE OCCUR						MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB CLAIMS-MADE						AGGREGATE	$
	DED RETENTION $							$
A	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y / N						X WC STATU-TORY LIMITS OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? **(Mandatory in NH)**	N / A		WCP39420	1/1/2013	1/1/2014	E.L. EACH ACCIDENT	$ 2,500,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 2,500,000
							E.L. DISEASE - POLICY LIMIT	$ 2,500,000

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

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CERTIFICATE HOLDER

Planned Parenthood of Southern NE
100 Grand Street
New Britain, CT 06052

CANCELLATION

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

AUTHORIZED REPRESENTATIVE

Lori Toussaint/LJT Lori Toussaint

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

STATE OF CONNECTICUT
INSPECTION CERTIFICATE

On **September 10, 2013** the New Britain Office of the Fire Marshal conducted an inspection of the **Hospital of Central Connecticut at New Britain General** located on **100 Grand St.** in the **City of New Britain** to determine the degree of compliance with the fire safety requirements of Connecticut General Statutes Chapter 541 as authorized by Section 29-305 of the statutes. This facility was evaluated as an **Existing Health Care** as classified by the *CONNECTICUT STATE FIRE SAFETY CODE*. As a result of this inspection, the following conditions were found:

I. ☑ At the time of inspection, no code violations were identified. **Certificate of approval recommended.**

II. ☐ At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. An acceptable plan of correction was submitted. (*See attached information*) **Certificate of approval recommended.**

III. ☐ At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. No approved plan of correction was submitted. (*See attached information*) **Certificate of approval NOT recommended.**

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IV. ☐ Based on the extreme hazard to public safety discovered at the time of this inspection, this office is currently seeking an injunction from the court through our Town/City Attorney for the purpose of closing or restricting usage of this facility by the public. (*See attached information*) **Certificate of approval NOT recommended.**

Raymond Decay
Act **Fire Marshal**

September 17, 2013
Date

City or Town: **New Britain**

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

Attachment 3

FORM 3

FACILITY/AGENCY NAME: Planned Parenthood of Southern New England

Form 3 must be completed if the facility/agency or Real Property Owner is owned/operated by a corporation (profit or non-profit). Please copy additional sheets if necessary.

For each stockholder with a 10% or greater ownership interest in the Licensee, provide the information requested below. If no owner owns 10% or more of the total shares, please indicate the two largest stockholders. **Please complete a separate form for each legal entity listed below that is not an individual.**

This information is for:
- ☑ Licensee _____
- ☐ Real Property Owner _____

1. Name: N/A
   Address: _____
   Telephone: _____
   Stockholder's percentage of ownership: _____
   Stockholder's occupation with the owner: _____

2. Name: _____
   Address: _____
   Telephone: _____
   Stockholder's percentage of ownership: _____
   Stockholder's occupation with the owner: _____

3. Name: _____
   Address: _____
   Telephone: _____
   Stockholder's percentage of ownership: _____
   Stockholder's occupation with the owner: _____

4. Name: _____
   Address: _____
   Telephone: _____
   Stockholder's percentage of ownership: _____
   Stockholder's occupation with the owner: _____

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING & INVESTIGATIONS SECTION

LICENSURE APPLICATION - ADDITIONAL INFORMATION REQUIRED

OUTPATIENT CLINICS, WELL CHILD CLINICS AND FAMILY PLANNING CLINICS

Please respond to all of the following questions:

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

100 Grand Street New Britain CT 06052 (203)238-0542
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. Samantha Dobson
Administrator (Your name needs to appear as it is shown on your Professional License).

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

5. Hours of Operation: T 4:30-7:30pm TH 4:30-7:30pm

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

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7. Business Fax Number: (203) 639-5085

8. Business Email Address: samantha.dobson@ppsne.org

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

S Dobson 11.12.13
Signature of Administrator Date Signed

Planned Parenthood of Southern New England

Services available:

- Well women's health care
- Well men's health care
- Cervical cancer screening
- Breast exams
- Sexually transmitted infection testing and treatment
- HIV testing
- Birth control services
- Pregnancy testing
- Options counseling
- Pre-conception care
- Medication abortion services
- Health and sexual health education services
- Hepatitis and HPV vaccine services
- Transgender services

9/13

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

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity ***Signature of FLIS Staff***

Planned Parenthood SNE
100 Grand St New Britain

M: Meriden Health Center
26 Women's Way Meriden CT 06457

Licensure Category: FP Clinic

Licensed Capacity: N/38 Census: ___
Licensed Capacity: ___ Census: ___

Date(s) of onsite inspection: 3/9/17

Date(s) additional information obtained: 3/17/17, 3/28/17

Personnel contacted: Sally Hellmuth Dir NS, Sarah Gantly APRN

REVIEW/FINDINGS/PROCESS (Complete all applicable categories)

[X] Licensing Inspection [ ] *Initial* [ ] *Renewal* [ ] *Other*: ___

[ ] Desk Audit ___ [ ] Amended Letter: ___ Original Ltr. ___

[ ] Revisit for the purpose of ___

[ ] See Complaint Investigation # ___

[ ] See Reportable Event Investigation # ___

[ ] See Certification File.

[ ] Violations of the General Statutes of Connecticut and/or regulations of Connecticut State Agencies were identified at the time of this inspection. See attached violation letter dated ___

[ ] Citation # ___ was issued to this facility as a result of this inspection.

[X] Violations of the General Statutes of Connecticut and/or the regulations of Connecticut State Agencies **were not** identified at the time of this inspection.

[ ] Citation # ___ was/was not verified as corrected. See attached narrative report.

[ ] Narrative report/additional information attached.

[ ] Referral(s) to ___

REPORT SUBMITTED BY: ___ **DATE OF REPORT:** 3/31/17

[ ] Approval for issuance of license granted by: Loan D Nguyen **DATE:** 3-31-17
Supervisor/Title

LICENSING INSPECTION NARRATIVE REPORT:

Additional Home Health Agency Information

- This Agency is authorized to provide the following services:
  [ ] Nsg.; [ ] PT; [ ] OT; [ ] ST; [ ] SS; [ ] H-HHA; [ ] IV Therapy;

  [ ] Other: _____

- Patient Services Offices (if applicable) :

  1. _____ 2. _____ 3. _____

  4. _____ 5. _____ 6. _____

  7. _____ 8. _____ 9. _____

- **Number of Home Visits:** 0 **Number of Records Recieved:** 4

Office Manager VA 2/9/17 2:05 4:30pm

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

DHSR

LICENSING INSPECTION REPORT

Name and Address of Entity

Planned Parenthood of Southern New England, Inc.
100 Grand Street
New Britain, CT 06051

Signature of DHSR Staff

Marsha A. Mehmel, RN, MPA, Nurse Consultant

Licensure Category : family planning clinic (located in the Hospital of Central CT → space rented)

Licensed ~~Capacity~~ #: 0038 **Census :** N/A

Licensed Capacity : _____ **Census :** _____

Date(s) of Onsite Inspection : May 2, 2013

Date(s) Additional Information Obtained: _____

Personnel Contacted : Jose Vargas, ACA; Kristine Sterling, APRN, → advanced clinical assistant; ARlinda Carr, ACA

REVIEW/FINDINGS/PROCESS (complete all applicable)

[X] Licensing Inspection: [ ] *Initial* [X] *Renewal* [ ] *Other:* _____

[ ] Revisit for the Purpose of _____

[ ] See Complaint Investigation # _____

[ ] See Reportable Event Investigation # _____

[ ] See Certification file.

[ ] Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were identified at the time of this inspection.
See violation letter dated _____

[ ] Citation # _____ was issued to this facility as a result of this inspection.

[X] Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were not identified at the time of this inspection.

[ ] Citation # _____ was verified as corrected. _____ was notified that the licensee was no longer required to post Citation (see narrative).

[ ] Citation # _____ was not corrected (see narrative).

[ ] Narrative Report / Additional Information Attached.

[ ] Referral(s) to: _____

REPORT SUBMITTED BY Marsha A. Mehmel, RN, MPA **DATE OF REPORT** 05/02/13

[X] Approval for Issuance of License granted by : Joan Drouin 7-24-13
Supervisor / Title Date

ENTITY: Planned Parenthood of Southern New England, Inc. New Britain

DATE(S) OF VISIT: May 2, 2013 Page 2 of 2

LICENSING INSPECTION NARRATIVE REPORT

Licensure inspection conducted onsite.
✓An entrance conference was held.

The following was inspected/reviewed:
✓- facility inspection
✓personnel files
✓quality assurance/clinical record review audit
✓fire drill log/disaster plan (Refer to hospital records.)
✓agency policies and procedures
✓clinical record review
✓- staff interviews
✓in-service (training) log
✓OSHA/infection control policies/procedures
✓review of bylaws, including organizational chart
✓CLIA certificate

✓An exit conference was conducted.

Violations of the Public Health Code of the State of Connecticut were not identified as a result of this inspection.

SIGNATURE Marsha A. Mehmel, RN, MPA
Name Consultant