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



Layluno

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 Halvin MD, MPH, MBA



Page 1 of

[] RELOCATION



[] INITIAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH FACILITY LICENSE & INVESTIGATIONS SECTION

LICENSURE APPLICATION

[] CHANGE OF OWNERSHIP

(V) RENEWAL

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. Plumbly Address as Name

| Plumbly Address | Plumb

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

is hereby made for a license to operate the follow	wing (please check the appropriate box that applies):
[] 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 [] 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
 Bed Capacity Requested (if applicable). please list the bed capacity for each level 	If submitting this application for multiple levels of care, of care being requested.
Level of Care Hemodialy	Passinets (if applicable) Bassinets (if applicable)
4. Disclose the legal entity which owns/opentity.) Planta Mark Mark Mark Mark Mark Mark Mark Mar	perates the facility. (Note: The license will be issued to this
Business Address Cit (Sand as above) Mailing Address (if applicable)	YEW) Haven at 10511 203-865-5758 State Zip Code Telephone
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

In accordance with Section 19a-491 and/or Section 19a-506 of the Connecticut General Statutes, application

7.	Please	e disclose the name, business address and telephone number of the Agent for Service for the								
	Licen	John 345 Whitney Avenue, New Hoven, CT Obsil 203-826-5158								
	Name	A MAN TO SELECTION OF THE SELECTION OF T								
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).								
	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.								
		 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.	Infor	th a current copy of the facility's Certificate of malpractice and public liability insurance. (Note: mation Pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be oted.). Please note that All Behavioral Health levels of care, except hospitals, and RCH facilities exempt from the malpractice requirement.								
11.		th evidence of current compliance with the worker's compensation insurance coverage rements 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.	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								
	CHEC	AMOUNT \$								
	DATE	RECEIVED INITIALS								

13. Annual Fire Marshal's Certificate of Inspection Form (attached) must be completed by the Loc 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 hospitalense. Additional forms may be copied if necessary. (Not applicable for Homemaker 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 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. A such false statement made therein is punishable by law, as per the CGS 53a-157b. Check one as applicable: [] Individual/Sole Proprietor [] General/Managing Partner [] President of Corporation [] Municipal Officer [] Trustee [] Member of the LLC State of Connecticut) County of New How How Institute of the statements contained in his/her answers to the foregoing questions. Hotary Public Notary Public Justice of the Peace []	eral
I attest that the information provided within this application is true and accurate and not made 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. A such false statement made therein is punishable by law, as per the CGS 53a-157b. 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 York of the statements contained in his/her answers to the foregoing questions. Suppose Heller of the statements contained in his/her answers to the foregoing questions.	on ospital's
I attest that the information provided within this application is true and accurate and not made 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. A such false statement made therein is punishable by law, as per the CGS 53a-157b. 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 York of the statements contained in his/her answers to the foregoing questions. Suppose Heller of the statements contained in his/her answers to the foregoing questions.	
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 Yell (State of Connecticut) Personally appeared before me the above named to the truth of the statements contained in his/her answers to the foregoing questions. Sulfatellame Notary Public	ny
[] 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 House is above named Though and mate to the truth of the statements contained in his/her answers to the foregoing questions. Sulf Affellements Notary Public	
County of New Hoven) ss John 2017 Personally appeared before me the above named John 1000 and ma to the truth of the statements contained in his/her answers to the foregoing questions. Substitute Notary Public	
County of New Hoven) ss John 2017 Personally appeared before me the above named John 1000 and ma to the truth of the statements contained in his/her answers to the foregoing questions. Substitute Notary Public	
to the truth of the statements contained in his/her answers to the foregoing questions. Sulf Affelleme Notary Public [9]	
Notary Public [9	made oath
Town Clerk [] Commissioner of the Superior Court [] My Commission Expires: (If Notary Public)	

SALLY HELLERMAN

NOTARY PUBLIC
MY COMMISSION EXPIRES DEC. 31, 2021



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.
п.	At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. An acceptable plan of correction was submitted. (See attached information) Certificate of approval recommended.
ш	At the time of inspection, conditions were discovered to be contrary to the minimum requirements of these codes. No approved plan of correction was submitted. (See attached information) Certificate of approval NOT recommended.
11	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 Warshal

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
	100 Grand St., New Britain, CT 06851
	Business Address City State Zip Code Telephone
2. Is t	his program a School Based Health Center? [] Yes
3.	Check the appropriate box/boxes describing the services to be provided by the clinic:
	[] Primary Care Family Planning
	[] Well Child Clinic [] Abortion Procedures
	[] Dental [] Mental Health Services
Be adv	vised 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 Sourcell, mo
	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 N	IUST 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 appsy. Ord Mandatory for Emergency Preparedness purposes

10. Business Cell Phone Number with Texting capabilities of the Administrator: 1203 305-4087

Mandatory for Emergency Preparedness purposes



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 LOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED RESENTATIVE 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

RODUCER	PTM NOTE OF			CONTA NAME:	СТ			
Marsh USA, Inc.			PHONE [A/C, No, Ext); (A/C, No):					
1166 Avenue of the Americ New York, NY 10036			E-MAIL ADDRE	ee.		[[A/C, NO].	A SOURCE HOME	
Attn: healthcare.accountsc	948-1307		ADDRE		SUPERIS) AFFOR	PDING COVERAGE	NAIC#	
09210-WC-5-5-16-17	WC		INSURER(S) AFFORDING COVERAGE INSURER A: N/A				N/A	
SURED				RB: ACE Amer	ican Insurance Co	ompany	22667	
PLANNED PARENTHOOD					RC: N/A			N/A
ENGLAND, INC., AN AFFII PARENTHOOD FEDERAT								140
345 WHITNEY AVENUE	•			INSURI				-
NEW HAVEN, CT 06511				INSURI				
OVERAGES	CER	TIEICAT	E NUMBER:	INSURI	-007090691-05		REVISION NUMBER:2	
INDICATED. NOTWIT CERTIFICATE MAY B EXCLUSIONS AND CO	HSTANDING ANY RI E ISSUED OR MAY	EQUIREME PERTAIN, POLICIES	NT, TERM OR CONDITION THE INSURANCE AFFOR LIMITS SHOWN MAY HAV	N OF AN	Y CONTRACT THE POLICIE REDUCED BY	OR OTHER	ED NAMED ABOVE FOR THE DOCUMENT WITH RESPECT D HEREIN IS SUBJECT TO A	TO WHICH THIS
R TYPE OF I	NSURANCE	INSD WVD	POLICY NUMBER		POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
COMMERCIAL GI	NERAL LIABILITY				7 7		EACH OCCURRENCE \$	
CLAIMS-MAI	OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence) \$	
							MED EXP (Any one person) \$	
							PERSONAL & ADV INJURY \$	
GEN'L AGGREGATE LI	MIT APPLIES PER:						GENERAL AGGREGATE \$	
POLICY PF	CT LOC						PRODUCTS - COMP/OP AGG \$	
OTHER:							\$	
JTOMOBILE LIABILIT	Y						COMBINED SINGLE LIMIT (Ea accident) \$	
ANY AUTO							BODILY INJURY (Per person) \$	116.
ALL OWNED AUTOS	SCHEDULED AUTOS						BODILY INJURY (Per accident) \$	
HIRED AUTOS	NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident) \$	
	The root						\$	
UMBRELLA LIAB	OCCUR						EACH OCCURRENCE \$	
EXCESS LIAB	CLAIMS-MADE						AGGREGATE \$	
DED RET	ENTION \$	1					s	
WORKERS COMPENSA	TION						X PER OTH-	
AND EMPLOYERS' LIAI ANY PROPRIETOR/PAR	THEDIEVECUTIVE TI	1 1	RSC C48130549	RSC C48130549		01/01/2017	E.L. EACH ACCIDENT \$	1,000
OFFICER/MEMBER EXC (Mandatory in NH)	LUDED?	N/A					E.L. DISEASE - EA EMPLOYEE \$	1,000
If yes, describe under DESCRIPTION OF OPE	PATIONS below						E.L. DISEASE - POLICY LIMIT \$	1,000
DESCRIPTION OF CITE	TOTO BOION						LILI DIGGINGE I GENT EMIT	
*								
SCRIPTION OF OPERATIC IDENCE OF COVERAGE.	NS / LOCATIONS / VEHIC	CLES (ACOR	D 101, Additional Remarks Sche	dule, may	be attached if mo	re space is requi	red)	
ERTIFICATE HOLD	ER			CAN	CELLATION	,		
PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND, INC. RAND STREET BRITAIN, CT 06052					EXPIRATIO	N DATE TH	DESCRIBED POLICIES BE CANDEREOF, NOTICE WILL BE CY PROVISIONS.	
					ORIZED REPRESI	ENTATIVE	77.541	***************************************

Rich. Ft

Ricki Fitzsimmons



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 SELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

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

certificate holder in lieu of such endors	sement(s).			5-		
PRODUCER Marsh USA, Inc.		CONTACT NAME:					
1166 Avenue of the Americas			PHONE				
New York, NY 10036	10 1007		E-MAIL ADDRESS:				
Attn: healthcare.accountscss@marsh.com Fax: 212-9	948-1307		INS	URER(S) AFFOR	DING COVERAGE		NAIC #
109210-NIP-CAS-17-18 NEW,C	PL		INSURER A : N/A				N/A
INSURED PLANNED PARENTHOOD OF SOUTHERN NEW			INSURER B : National Un	ion Fire Ins. Co.	of Pittsburgh, PA		19445
ENGLAND, INC., AN AFFILIATE OF PLANNED			INSURER C:				
PARENTHOOD FEDERATION OF AMERICA, INC.			INSURER D :				
345 WHITNEY AVENUE NEW HAVEN, CT 06511			INSURER E :				
			INSURER F:				
COVERAGES CER	TIFICAT	E NUMBER:	NYC-007478051-03		REVISION NUMBER:2		
THIS IS TO CERTIFY THAT THE POLICIES INDICATED. NOTWITHSTANDING ANY RE CERTIFICATE MAY BE ISSUED OR MAY EXCLUSIONS AND CONDITIONS OF SUCH	PERTAIN, POLICIES	ENT, TERM OR CONDITION THE INSURANCE AFFORD I. LIMITS SHOWN MAY HAVE	OF ANY CONTRACT ED BY THE POLICIE BEEN REDUCED BY	OR OTHER S DESCRIBE	DOCUMENT WITH RESPECT TO	CT TO	WHICH THIS
INSR LTR TYPE OF INSURANCE	ADDL SUBF	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	(MM/DD/YYYY)	LIMIT	S	
COMMERCIAL GENERAL LIABILITY	64				EACH OCCURRENCE	\$	
CLAIMS-MADE OCCUR					DAMAGE TO RENTED PREMISES (Ea occurrence)	\$	
					MED EXP (Any one person)	s	
					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 SCHEDULED AUTOS					BODILY INJURY (Per accident)	\$	
HIRED AUTOS NON-OWNED AUTOS					PROPERTY DAMAGE (Per accident)	\$	
			200			\$	
UMBRELLA LIAB OCCUR					EACH OCCURRENCE	\$	
EXCESS LIAB CLAIMS-MADE					AGGREGATE	\$	
DED RETENTION \$					DED OTH	\$	
WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N					PER OTH- STATUTE ER		
ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED?	N/A				E.L. EACH ACCIDENT	\$	
(Mandatory in NH) If yes, describe under					E.L. DISEASE - EA EMPLOYEE	\$	
DESCRIPTION OF OPERATIONS below					E.L. DISEASE - POLICY LIMIT	\$	
B MEDICAL PROFESSIONAL		6793286	01/01/2017	01/01/2018	EACH WRONGFUL ACT		\$1,000,000
CLAIMS-MADE COVERAGE		Program Retro Date: 11/1/76			AGGREGATE		\$3,000,000
DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICL EVIDENCE OF COVERAGE FOR HEALTH CENTER	CLES (ACOR	RD 101, Additional Remarks Sched	ule, may be attached if mo	re space is requi	red)		
CERTIFICATE HOLDER			CANCELLATION				
PLANNED PARENTHOOD OF SOUTHERN NEW ENGLAND 1000 GRAND STREET NEW BRITAIN, CT 06052				N DATE TH	DESCRIBED POLICIES BE C EREOF, NOTICE WILL CY PROVISIONS.		
			AUTHORIZED REPRESE of Marsh USA Inc.	ENTATIVE			
			Ricki Fitzsimmons		Rich. Fitz		



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

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PRODUCER			CON	TACT				
Marsh USA, Inc.			PHC	CONTACT NAME: PHONE FAX				
1166 Avenue of the Americas New York, NY 10036			(A/C	, No, Ext):		FAX (A/C, No):		
Attn: healthcare.accountscss@marsh.com Fa	x: 212-948	1307	ADC	RESS:			T	
						RDING COVERAGE	NAIC #	
	EW,C G	_PL		URER A : New Ham				
NSURED PARENTHOOD OF SOUTHERN	NEW			URER B : National U	nion Fire ins. Co.	or Pittsburgh, PA	19445	
ENGLAND, INC.	,		INS	INSURER C:				
AN AFFILIATE OF PLANNED PARENTHOO FEDERATION OF AMERICA, INC.	,		INS	URER D :				
345 WHITNEY AVENUE				URER E :				
NEW HAVEN, CT 06511			Photographic and the second se	URER F :				
COVERAGES THIS IS TO CERTIFY THAT THE PO				YC-007483661-29		REVISION NUMBER: 11	DI IOV PEDIOD	
INDICATED. NOTWITHSTANDING A CERTIFICATE MAY BE ISSUED OR EXCLUSIONS AND CONDITIONS OF INSTRUCTOR TYPE OF INSURANCE A X COMMERCIAL GENERAL LIABILIT	MAY PE SUCH PO	RTAIN,	THE INSURANCE AFFORDED I	BY THE POLICIE	S DESCRIBE	D HEREIN IS SUBJECT TO ALI		
CLAIMS-MADE X OCCU				20000000000000000000000000000000000000	perfection of the second	DAMAGE TO RENTED PREMISES (Ea occurrence) \$	500,000	
X SIR: \$100,000						MED EXP (Any one person) \$	Included	
						PERSONAL & ADV INJURY \$	1,000,000	
GEN'L AGGREGATE LIMIT APPLIES PER						GENERAL AGGREGATE \$	2,000,000	
POLICY PRO- X LOC						PRODUCTS - COMP/OP AGG \$	2,000,000	
OTHER:	3.51					S S	2,000,000	
AUTOMOBILE LIABILITY				6		COMBINED SINGLE LIMIT (Ea accident) \$		
ANY AUTO						BODILY INJURY (Per person) \$		
ALL OWNED SCHEDUL	D					BODILY INJURY (Per accident) \$		
NON-OWN	ED					PROPERTY DAMAGE		
HIRED AUTOS AUTOS						(Per accident)		
UMBRELLA LIAB OCCU	2					EACH OCCURRENCE \$		
EVOCCOLLAD	S-MADE					AGGREGATE \$		
DED RETENTION \$						S		
WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						PER OTH-		
ANY PROPRIETOR/PARTNER/EXECUTIVE	Y/N					E.L. EACH ACCIDENT \$		
OFFICER/MEMBER EXCLUDED? (Mandatory in NH)		A				E.L. DISEASE - EA EMPLOYEE \$		
If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - POLICY LIMIT \$		
B MEDICAL PROFESSIONAL			6793286	01/01/2017	01/01/2018	EACH WRONGFUL ACT	\$1,000,000	
CLAIMS-MADE COVERAGE			Program Retro Date: 11/1/76			AGGREGATE	\$3,000,000	
DESCRIPTION OF OPERATIONS / LOCATIONS	/ VEHICLES	(ACORI	0 101, Additional Remarks Schedule, m	ay be attached if mo	ore space is requi	red)		
CERTIFICATE HOLDER			CA	NCELLATION				
PLANNED PARENTHOOD OF SOUTHERN ENGLAND ATTN: LOUIS DENEGRE 345 WHITNEY AVENUE	NEW		1	HE EXPIRATIO	N DATE TH	DESCRIBED POLICIES BE CANCE EREOF, NOTICE WILL BE I CY PROVISIONS.	ELLED BEFORE DELIVERED IN	
NEW HAVEN, CT 06511				THORIZED REPRES Marsh USA Inc.	ENTATIVE			



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).

certificate holder in lieu of such endorsemer	nt(s).					
PRODUCER Marsh USA, Inc.	CONTACT NAME:					
1166 Avenue of the Americas	PHONE FAX (A/C, No, Ext): (A/C, No):					
New York, NY 10036	17	E-MAIL ADDRESS:				
Attn: healthcare.accountscss@marsh.com Fax: 212-948-130				DING COVERAGE		NAIC#
109210-NIP-CAS-17-18 NEW,C GL	Market Control	INSURER A : New Hamp	oshire Insurance C	Company		23841
INSURED PLANNED PARENTHOOD OF SOUTHERN NEW		INSURER B : N/A				N/A
ENGLAND, INC.		INSURER C:				
AN AFFILIATE OF PLANNED PARENTHOOD		INSURER D :				
FEDERATION OF AMERICA, INC. 345 WHITNEY AVENUE		INSURER E :				
NEW HAVEN, CT 06511		INSURER F :				
COVERAGES CERTIFIC	ATE NUMBER:	NYC-007479796-31	1 1 1 1 1	REVISION NUMBER:2		
THIS IS TO CERTIFY THAT THE POLICIES OF II INDICATED. NOTWITHSTANDING ANY REQUIR CERTIFICATE MAY BE ISSUED OR MAY PERTIEXCLUSIONS AND CONDITIONS OF SUCH POLICE.	EMENT, TERM OR CONDITION AIN, THE INSURANCE AFFORD CIES. LIMITS SHOWN MAY HAVE	OF ANY CONTRACT DED BY THE POLICIE BEEN REDUCED BY	OR OTHER I S DESCRIBED PAID CLAIMS.	DOCUMENT WITH RESPE D HEREIN IS SUBJECT TO	CT TO	WHICH THIS
INSR LTR TYPE OF INSURANCE INSD	SUBR WVD POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMIT	rs	
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)	s	Included
				PERSONAL & ADV INJURY	s	1,000,000
GEN'L AGGREGATE LIMIT APPLIES PER:				GENERAL AGGREGATE	s	2,000,000
POLICY PRO- X LOC				PRODUCTS - COMP/OP AGG	\$	2,000,000
OTHER:		M. I			\$	
AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT (Ea accident)	\$	
ANY AUTO				BODILY INJURY (Per person)	\$	
ALL OWNED SCHEDULED AUTOS				BODILY INJURY (Per accident)	\$	
HIRED AUTOS NON-OWNED AUTOS				PROPERTY DAMAGE (Per accident)	\$	
70103				(Fer accident)	\$	
UMBRELLA LIAB OCCUR				EACH OCCURRENCE	s	
EXCESS LIAB CLAIMS-MADE				AGGREGATE	s	
DED RETENTION \$					s	
WORKERS COMPENSATION				PER OTH-		
AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? N/A				E.L. EACH ACCIDENT	s	
OFFICER/MEMBER EXCLUDED? (Mandatory in NH)				E.L. DISEASE - EA EMPLOYEE	-	
If yes, describe under DESCRIPTION OF OPERATIONS below				E.L. DISEASE - POLICY LIMIT		
DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (A	CORD 101. Additional Remarks Schedu	ule, may be attached if mo	re space is requi	red)		
CERTIFICATE HOLDER		CANCELLATION				
NEW BRITAIN GENERAL HOSPITAL ATTN: NANCY KROEBER 100 GRAND STREET NEW BRITAIN, CT 06050			N DATE THE	ESCRIBED POLICIES BE OF EREOF, NOTICE WILL CY PROVISIONS.		
		AUTHORIZED REPRESI of Marsh USA Inc.	ENTATIVE			
		Ricki Fitzsimmons		Rich Fitze		

2013

RENEWAL



[] INITIAL

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH FACILITY LICENSE & INVESTIGATIONS SECTION

LICENSU	RE APPLICATION
[] RENEWAL	[] CHANGE OF OWNERSHIE

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	[] Infirmary Operated by an Educational Institution
[] Children's Hospital	[] Maternity Home
[] Chronic and Convalescent Nursing Home	[] Maternity Hospital
[] Chronic Disease Hospital	Outpatient Clinic/Primary Caregy 2 0 2013
[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	[] 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

<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

1 icas	e respond to an or the following questions:
1.	Planned Paventhood of Southern NAN Englar Facility "d/b/a" (doing business as) Name
	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.
	Beds/
	Level of Care Hemodialysis Stations Bassinets (if applicable)
¹ 3.	DIODA 1035105 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 Whithey AVR NAWHOLD CT DUSH (208) 805-5158
	Business Address City State Zip Code Telephone
	same Diagativa
	Mailing Address (if applicable)
	Walling Address (II 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:
	Non-profit Corporation
√6.	Is the above named entity authorized by the Office of the Secretary of State to transact business in the State of Connecticut and considered in Good Standing? [VYES [] NO

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

 JUNE TOUSI (218) 805-5158

 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 <u>trust</u>, complete Form 2 (attached) for the Licensee.
 - i. Attach a list including the name, address and telephone number of all trustees.
 - C. If the Licensee is a <u>corporation</u> (profit or non-profit), complete Form 3 (attached) for the Licensee. Complete a separate Form 3 for each additional corporate entity having 10% or greater ownership interest in the Licensee.
 - i. If the corporation is incorporated in a state other than Connecticut, please attach a Certificate of Good Standing from the Secretary of State of the state of incorporation.
 - 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: <u>Information pages and Insurance Binders are unacceptable. Only Certificates of Insurance will be accepted.</u>)
- Ownership of Real Property

 ONNECTICUT

 Name

 ONNECTICUT

 Name

 ONNECTICUT

 Name

 ONNECTICUT

 Name

 ONNECTICUT

 Name

 ONNECTICUT

 State Zip Code Telephone

			OR OFFICE US	******* <u>E ONLY</u>	
	CHECK #		AMOUNT	T \$	
	DATE RECEIVED		INITIALS		
****	***********	*******	*****	*******	******
13.	Annual Fire Marshal's Certificate of Marshal. NOTE: Hospitals must completed for each building on t license. Additional forms may be Certificate of Inspection that is s Homemaker Home Health and H	have a sepa he hospital e copied if a submitted m	arate Fire Mar 's campus and necessary. Eac nust have an o	rshal's Certificate each satellite liste ch completed Fire	of Inspection d on the hospital's Marshal's
14.	Affidavit of Owner: I attest that the information provide in the information submitted will be				
	Signature Signature	Ē	11/8/13 Date Signed		
	Check one as applicable:				
	 Individual/Sole Proprietor General/Managing Partner President of Corporation Secretary of Corporation Municipal Officer Trustee 			D) BCB	IVEIN
	State of Connecticut)		MOV 2 0	2013
	County of New Howe) s:	s_4/F	20 13	
	Personally appeared before me the to the truth of the statements conta			Tabar the foregoing questi	and made oath
			SallyAL	fellum	
			lotary Public ustice of the Pe	ace	
			own Clerk	of the Superior Cour	()
	My Commission Expires:		ommissioner o	Tale Superior Cour	
	Nofaty Publ	Heilerman lio-Conneci lission Expir per 31, 2016	98 II		

FLIS LICAPP -001 Rev. 8/13



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(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 confer rights to the certificate holder in lieu of such endorsement(s). CONTACT NAME: PHONE (A/C, No. Ext): E-MAIL ADDITECT PRODUCER Marsh USA, Inc. FAX (A/C, No): 1166 Avenue of the Americas New York, NY 10036 ADDRESS: NAIC # INSURER(S) AFFORDING COVERAGE 38970 Markel Insurance Company INSURER A: N/A INSURER B : NA INSURED INSURER C: National Union Fire Ins. Co. of Pittsburgh, PA PLANNED PARENTHOOD OF 19445 SOUTHERN NEW ENGLAND, INC. AN AFFILIATE OF PLANNED PARENTHOOD INSURER D FEDERATION OF AMERICA, INC. INSURER E : 345 WHITNEY AVENUE NEW HAVEN, CT 06511 INSURER F: **REVISION NUMBER:** CERTIFICATE NUMBER: NYC-005757681-25 COVERAGES THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED, NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS. POLICY EFF POLICY EXP ADDL SUBR LIMITS TYPE OF INSURANCE POLICY NUMBER 1,000,000 01/01/2013 01/01/2014 EACH OCCURRENCE S GENERAL LIABILITY DAMAGE TO RENTED PREMISES (Ea occurrence) 100,000 X COMMERCIAL GENERAL LIABILITY 5.000 MED EXP (Any one person) CLAIMS-MADE X OCCUR 1,000,000 PERSONAL & ADV INJURY SIR: \$100,000 2,000,000 \$ **GENERAL AGGREGATE** 2,000,000 PRODUCTS - COMP/OP AGG 5 GEN'L AGGREGATE LIMIT APPLIES PER: X LOC POLICY PRO-COMBINED SINGLE LIMIT (Ea accident) AUTOMOBILE LIABILITY **BODILY INJURY (Per person)** ANY AUTO SCHEDULED AUTOS NON-OWNED AUTOS BODILY INJURY (Per accident) 5 ALL OWNED PROPERTY DAMAGE (Per accident) \$ HIRED AUTOS \$ EACH OCCURRENCE UMBRELLA LIAB OCCUR AGGREGATE **EXCESS LIAB** CLAIMS-MADE RETENTION \$ DED WC STATU-TORY LIMITS WORKERS COMPENSATION AND EMPLOYERS' LIABILITY E.L. EACH ACCIDENT ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) E.L. DISEASE - EA EMPLOYEE If yes, describe under DESCRIPTION OF OPERATIONS below E.L. DISEASE - POLICY LIMIT \$1,000,000 PER CLAIM 01/01/2013 01/01/2014 6793286 MEDICAL PROFESSIONAL \$3,000,000 AGGREGATE Program Retro Date: 11/1/76 CLAIMS-MADE COVERAGE DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Atlach ACORD 101, Additional Remarks Schedule, if more space is required) MOV 2 0 2013 CANCELLATION CERTIFICATE HOLDER SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE PLANNED PARENTHOOD OF SOUTHERN NEW THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. **ENGLAND** ATTN: LOUIS DENEGRE 345 WHITNEY AVENUE NEW HAVEN, CT 06511 AUTHORIZED REPRESENTATIVE of Marsh USA Inc. Rich. Fitzen Ricki Fitzsimmons



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.

certificate holder in lie	eu of such endo	rsement(s).		CONT	ACT Lori To				
	ongo Agges	istor						EAY	
Lindquist Insurance Associates 24 Lexington St		PHONE (A/C. No. Ext): (860) 224-2413 FAX (A/C. No.): (860) E-MAIL ADDRESS: Lori . Tousssaint@lindquist-insurance				0) 225-8917			
24 Lexington St				ADDR				insuranc	
New Britain	CT 0	6052		-		1-1	RDING COVERAGE		NAIC #
INSURED	CI U	0032				Workers	Compensat	ion	
	and Of Ca	Non En	aland Tax	INSURER B:					
345 Whitney Ave	Parenthood Of So. New England, Inc			INSURER C:					
343 Will they Ave				INSURER D :					
New Haven	CT 0	6511		INSUR					
COVERAGES			NUMBER:CL134110	INSUR	ERF:		REVISION NUI	ADED:	
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GENERAL LIABILITY	URANCE	INSR WVD	POLICY NUMBER		(MM/DD/YYYY)	(MM/DD/YYYY)		LIMITS	
COMMERCIAL GENE	DALLIADULTY						DAMAGE TO RENT	FD	
CLAIMS-MADE	OCCUR						PREMISES (Ea occ		
CLAIMS-MADE	OCCOR						MED EXP (Any one		
							PERSONAL & ADV		
GEN'L AGGREGATE LIMIT	APPLIES DER						PRODUCTS - COM		
POLICY PRO- JECT	LOC						PRODUCTS - COM	S S	
AUTOMOBILE LIABILITY	1 100						COMBINED SINGLE	and the same of th	
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ALL OWNED AUTOS	SCHEDULED AUTOS						BODILY INJURY (P		
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	7 40100						(Per accident)	\$	
UMBRELLA LIAB	OCCUR						EACH OCCURREN	CE \$	
EXCESS LIAB	CLAIMS-MADE						AGGREGATE	s	
DED RETENT	ION S							s	
A WORKERS COMPENSATION AND EMPLOYERS' LIABIL	ITY						X WC STATU- TORY LIMITS	OTH- ER	
ANY PROPRIETOR/PARTN OFFICER/MEMBER EXCLU	ER/EXECUTIVE	N/A					E.L. EACH ACCIDE	States Williams N. Co.	2,500,000
(Mandatory in NH)			WCP39420		1/1/2013	1/1/2014	E.L. DISEASE - EA	EMPLOYEE \$	2,500,000
If yes, describe under DESCRIPTION OF OPERA	TIONS below						E.L. DISEASE - POI	LICY LIMIT S	2,500,000
							1	CEIT	VEL
DESCRIPTION OF OPERATIONS	/ LOCATIONS / VEHI	CLES (Attach	ACORD 101, Additional Rem	arks Sched	ile, if more space	is required)	KI	10V 2 0	2013
CERTIFICATE HOLDER	2			CAN	CELLATION				
Planned Par 100 Grand S		Southe	ern NE	THE	EXPIRATION	N DATE THE			DELIVERED IN
New Britain		2		AUTHO	RIZED REPRESE	ENTATIVE			

ACORD 25 (2010/05)

The ACORD name and long are registered marks of ACORD

Lori Toussaint/LJT

Lou 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:

information) Certificate of approval NOT recommend IV. Based on the extreme hazard to public safety disce this office is currently seeking an injunction from the c for the purpose of closing or restricting usage of this information) Certificate of approval NOT recommend	overed at the time of this inspection ourt through our Town/City Attorne facility by the public. (See attached
Raymal Decay Am Fire Marshal	September 17, 2013 Date



STATE OF CONNECTICUT

Attachment 3

DEPARTMENT OF PUBLIC HEALTH FACILITY LICENSING & INVESTIGATIONS SECTION

FORM 3

FACILITY/AGENCY NAME: PLOWINGED POULLYTH WOOD OF SOUTHOWN 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: NIA	
	Address:	
	Telephone:	
	Stockholder's percentage of ownership:	
	Stockholder's occupation with the owner:	
2.	Name:	
2.	Name:	
	Address:Telephone:	
	Stockholder's percentage of ownership:	
	Stockholder's occupation with the owner:	
3.	Name:	
	Address:	
	Telephone:	
	Stockholder's percentage of ownership:	D) 4 PRIVEL
	Stockholder's percentage of ownership: Stockholder's occupation with the owner:	10110
4.	Name:	THE PLANT OF THE PARTY OF THE P
	Address:	The an extend organization
	Telephone:	
	Stockholder's percentage of ownership:	accept of some
	Stockholder's occupation with the owner:	





Page 1 of 3

Page 1 of 1

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 Poul Hood of Southern New England
Facility "d/b/a" (doing business as) Name

	Facility "d/b/a" (doing business as) Name
	100 Gray Street New Britain CT DLOS 2 (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 [Family Planning [] Well Child Clinic [] Abortion Procedures [] Dental
3,	Samovition DOSON Administrator (Your name needs to appear as it is shown on your Professional License).
4.	Medical Director Dental Director (if applicable) (Your name needs to appear as it is shown on your Professional License).
5.	Hours of Operation: T4:30-7:30pm TH4:30-7:30pm
6	Please provide a list of services that will be provided.
7.	Business Fax Number: (203) U39-5085
8,	Business Email Address: Samantha. Danson @ppsne. 049
9.	Business Cell Phone Number with Texting capabilities of the Administrator:
E	27 hon 11:12:12

Date Signed

Signature of Administrator

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



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

Page 1 of ____

LICENSING INSPECTION REPORT

d/b/a Name and Address of Entity	Signature of FLIS Staff Semmen
100 grand ST New Bril	Jeuninen Jeuninen
M: Merilen Hearth Centry	
26 Women's Way Merche. Licensure Category:	Licensed Capacity: M38 Census: Census: Census:
Date(s) of onsite inspection: $\frac{3/9/(1-x)}{2}$	7
Date(s) additional information obtained	: 3/17/17, 3/28/17,
Personnel contacted: Sully Hul	: 3/17/17, 3/28/17, lumen Dr Ms, Farch Gandly ARA
REVIEW/FINDINGS/PROCESS (Comp	
Desk Audit	[] Amended Letter:Original Ltr
[] Revisit for the purpose of	
[] See Complaint Investigation #	
[] See Reportable Event Investigation	#
[] See Certification File.	
	of Connecticut and/or regulations of Connecticut State Agencies were tion. See attached violation letter dated
[] Citation # was i	ssued to this facility as a result of this inspection.
Violations of the General Statutes of were not identified at the time of the violations of the violations of the General Statutes of the violations of violations of the violations of the violations of violations of v	of Connecticut and/or the regulations of Connecticut State Agencies his inspection.
[] Citation #was/w	vas not verified as corrected. See attached narrative report.
[] Narrative report/additional informa	tion attached.
[] Referral(s) to	
REPORT SUBMITTED BY:	anted by: Loan Dhayen DATE: 3-31-17
Approval for issuance of license gr	anted by: Lean Dhouyen DATE: 3-31-17 Supervisor/Title
s:flis\hsr\FACESHEETS	

Revised 12/2016

Page 2 of ___

STRIKE MONITORING SUPPLEMENT TO LICENSING INSPECTION REPORT

LICENSING INSPECTION NARRATIVE REPORT:

atient Services Of	fices (if applicable) :			
	2	• .	3.	
	5		б	
	8.		9.	

apper many NA 3/9/17 20 \$ 430m ()

DHSR

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

Page 1 of 2

LICENSING INSPECTION REPORT

Name and Address of Entity Signature of DHSR Staff
Planned Parendhood of Southern new England, Inc.
New Britain, CT 06051 Musha a. Mehmel, Ru, MPA, Nuse
Consultant
Licensure Category: Licensed Capacity: 0038 Census: NA
1 (1) (14) 1 is tel the sital of
Central CT > space sented Licensed Capacity: Census:
Date(N) of Onsite Inspection: May 2,2013
Date(s) Additional Information Obtained:
Personnel Contacted: Jose Vargas, ACA; Kristine Sterling, APAN,
REVIEW/FINDINGS/PROCESS (complete all applicable) ARlinda Carr, ACA
Licensing Inspection: [] Initial [] Renewal [] Other:
Revisit for the Purpose of
See Complaint Investigation #
See Reportable Event Investigation #
See Certification file.
Violations of the Public Health Code of the State of Connecticut and/or Regulations of Connecticut State Agencies were identified at the time of this inspection. See violation letter dated
() Citation # was issued to this facility as a result of this inspection.
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.
1 Referral(s) to:
REPORT SUBMITTED BY Musha Q. Mehmel Rn, MPA DATE OF REPORT 05/02/13
Approval for Issuance of License granted by: Gan Drougen 7-24-13 Supervisor / Title Date
Supervisor / Title Date

ENTITY: Planned Parenthood of Southern New England, Inc.

DATE(S) OF VISIT: May 2, 2013

Page 2 of 2

LICENSING INSPECTION NARRATIVE REPORT

Licensure inspection conducted onsite.

An entrance conference was help.

The following was inspected/reviewed:

- facility inspection

personnel files

quality assurance/clinical record review audit

fire drill log/disaster plan (Refer to hospital records.)

ragency 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. Melimel, Pu, MPA