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## SUPPLEMENT FOR MEDICAL SPA/ANTI-AGING CLINICS

### (USE WITH APPLICATION FOR CLINICS (MEDICAL, PUBLIC HEALTH, DENTAL, ETC.) PROFESSIONAL LIABILITY INSURANCE (SM-30006))

All questions MUST be completed in full.

If space is insufficient to answer any question fully, attach a separate sheet.

## I. GENERAL INFORMATION

1. Full name of Applicant: _____

## II. OPERATIONS

1. What is the professional specialty of the clinic? _____

2. (a) Provide a list of the Applicant's Medical Director(s): _____

   (b) Attach a CV for each of the Applicant's Medical Directors and a description of their duties.

3. Provide the percentage of the Applicant's patients/clients in the following categories:

| | | | |
|---|---|---|---|
| (a) Acupuncture | _____% | Plastic Surgery | _____% |
| Beauty Shop (nails, hair, facials) | _____% | Research or Experimental | _____% |
| Chelation Therapy | _____% | Sclerotherapy | _____% |
| Dental | _____% | Surgical | _____% |
| Dermatology | _____% | Weight Control | _____% |
| Hormone Therapy | _____% | Other (specify) | |
| Massage | _____% | _____ | _____% |
| Medical Spa | **_____%** | **TOTAL** | **100**% |

4. Applicant's practice is run by:

| | | |
|---|---|---|
| ___ Doctor | ___ Plastic Surgeon | ___ Other – describe |
| ___ Dentist | ___ Nurse | _____ |
| ___ Dermatologist | ___ Administrator | |

## III. PROFESSIONAL SERVICES

1. List all manufactured equipment and drugs used in the Applicant's practice and the purpose for which each is used. Attach separate sheet if necessary:

| Equipment/Drug | Purpose | Used only as approved by the FDA? (Yes or No) | If No, describe off-label usage. |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

2. Does the Applicant take before and after pictures of every patient? .....[ ] Yes [ ] No
   If No, explain. _____

3. Must all clients sign a patient consent form specific to the procedures to be performed prior to treatment? .....[ ] Yes [ ] No
   If No, explain. _____

## IV. PROCEDURES

1. Botox Injections

Does the Applicant perform Botox Injections? .....[ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Botox Injections: ..... (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Botox Injections?.....

___ Physician ___ Physician's Assistant ___ Nurse

___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(c) Have all staff performing Botox Injections:

(i) Received a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? .....[ ] Yes [ ] No

(ii) Performed a minimum of ten procedures on live patients? .....[ ] Yes [ ] No

(d) Does the Applicant have a physician available for consultation and complications?.....[ ] Yes [ ] No

If Yes,

(i) Has this physician completed a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient?.....[ ] Yes [ ] No

(ii) Does the physician have Medical Malpractice Liability Insurance for this activity? .....[ ] Yes [ ] No

If No, submit a separate application for each physician to be included.

2. Chemical Peels

Does the Applicant perform Chemical Peels? .....[ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Chemical Peels with solution strength <30%: . (i) Past 12 months: _____ (ii) Next 12 months: _____

(i) Who performs Chemical Peels with solution strength <30%:

___ Physician ___ Physician's Assistant ___ Nurse

___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(ii) Have all staff performing Chemical Peels with solution strength <30% received a minimum of eight hours training specifically for this procedure including anatomy, physiology, skin typing, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? .....[ ] Yes [ ] No

(b) Total number of Chemical Peels with solution strength >30%: . (i) Past 12 months: _____ (ii) Next 12 months: _____

(i) Who performs Chemical Peels with solution strength >30%:

___ Physician ___ Physician's Assistant ___ Nurse

___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(ii) Are all staff performing Chemical Peels with solution strength >30% licensed physicians with a specialty of Dermatology or Plastic Surgery?.....[ ] Yes [ ] No

3. Dermal Fillers

Does the Applicant perform Dermal Fillers (Artefill, Collagen, Hylaform, Restylane)? .....[ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Dermal Fillers: ..... (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Dermal Fillers?

___ Physician ___ Physician's Assistant ___ Nurse

___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(c) Have all staff performing Dermal Fillers:

(i) Received a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? .....[ ] Yes [ ] No

(ii) Performed a minimum of five procedures on live patients?.....[ ] Yes [ ] No

Dermal Fillers continued

(d) Does the Applicant have a physician available for consultation and complications? .....[ ] Yes [ ] No

If Yes,

(i) Has this physician completed a minimum of eight hours training specific for this procedure including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of at least one procedure on a live patient? .....[ ] Yes [ ] No

(ii) Does this physician have Medical Malpractice Liability Insurance for this activity?.....[ ] Yes [ ] No
If No, submit a separate application for each physician to be included.

(e) Does the Applicant

(i) Use only dermal fillers approved by the FDA? .....[ ] Yes [ ] No
If No, explain:_____

(ii) Disclose off-label use to all patients receiving such treatment on the patient consent form? .....[ ] Yes [ ] No

4. Laser Skin Treatments

Does the Applicant perform Laser Skin Treatments including Laser Hair Removal, IPL (Intense Pulse Light Treatments), Acne Blue Light Treatments, and Laser Vein Treatments? .....[ ] Yes [ ] No
If Yes, complete the following:

(a) Total number of Laser Skin Treatments: ..... (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Laser Skin Treatments Injections?

___ Physician ___ Physician's Assistant ___ Nurse
___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(c) Does the Applicant comply with the following standards of practice:

(i) Individuals are trained in laser physics, tissue interaction, laser safety, clinical application, pre-operative care, and post-operative care of the laser patient. .....[ ] Yes [ ] No

(ii) Prior to the initiation of any patient care activity the individual has read and sign the clinic's policies and procedures regarding the safe use of lasers. .....[ ] Yes [ ] No

(iii) Continuing education of all licensed medical professionals is mandatory and made available with reasonable frequency (including outside the office setting) to help insure adequate performance. (Specific credit hour requirements will be determined by the state and/or individual clinic.) .....[ ] Yes [ ] No

(iv) A minimum of ten procedures of precepted training is required for each laser procedure and laser type to assess competency. Participation in all training programs, acquisition of new skills and number of hours spent in maintaining proficiency is well documented.....[ ] Yes [ ] No

(v) After demonstrating competency to act alone, the designated licensed medical professional may perform limited laser treatments on specific patients as directed by the supervising physician. .....[ ] Yes [ ] No

(d) Does the Applicant comply with the following standards of practice for non-physicians use of laser related technology:

(i) Any physician who delegates a procedure to a non-physician must be qualified to do these laser procedures themselves by virtue of having received appropriate training in physics, safety, surgical techniques, pre and post operative care, and be able to handle the resultant emergencies or sequela.....[ ] Yes [ ] No

(ii) Any licensed medical professional employed by a physician to perform a procedure has received appropriate documented training and education in the safe and effective use of each system and are a licensed medical professional in the state of practice. .....[ ] Yes [ ] No

(iii) A properly trained and licensed medical professional carries out these specifically designed procedures only under the direct, on-site physician supervision and following written procedures. .....[ ] Yes [ ] No

(iv) The supervising physician is available on-site to respond to any untoward event that may occur. Ultimate responsibility lies with the supervising physician.....[ ] Yes [ ] No

5. Massage Therapy/Cellulite Treatments

Does the Applicant perform Massage Therapy/Cellulite Treatments? .....[ ] Yes [ ] No
If Yes, complete the following:

(a) Total number of Massage Therapy / Cellulite Treatments: .... (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Massage Therapy / Cellulite Treatments?

___ Physician ___ Physician's Assistant ___ Nurse
___ Massage Therapist ___ Nurse Practitioner ___ Other-describe: _____

Massage Therapy/Cellulite Treatments continued

(c) Are all staff performing Massage Therapy / Cellulite Treatments licensed, registered or certified according to state requirements? .....[ ] Yes [ ] No
If No, explain. _____

6. Mesotherapy and/or Lipodissolve

Does the Applicant perform Mesotherapy and/or Lipodissolve at this clinic? .....[ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Mesotherapy/Lipodissolve Treatments: ..... (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Mesotherapy/Lipodissolve at this clinic?

___ Physician ___ Physician's Assistant ___ Nurse
___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(c) Are all staff performing Mesotherapy and/or Lipodissolve licensed physicians with a minimum of eight hours training to perform Mesotherapy and/or Lipodissolve including anatomy, physiology, contraindications, potential complications, and performance of at least one procedure on each part of the anatomy for which coverage is desired?.....[ ] Yes [ ] No

7. Microdermabrasions

Does the Applicant perform Microdermabrasions? .....[ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Microdermabrasions: ..... (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Microdermabrasion:

___ Physician ___ Physician's Assistant ___ Nurse
___ Dentist ___ Nurse Practitioner ___ Other-describe:

(c) Have all staff performing Microdermabrasion treatments received a minimum of eight hours training including specific training for the equipment being used, skin typing, contraindications, potential complications, and performance of at least one procedure on a live patient? .....[ ] Yes [ ] No
If No, explain: _____

8. Micropigmentation / Permanent Makeup

Does Applicant perform Micropigmentation / Permanent Makeup? .....[ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Permanent Makeup / Micropigmentations: .. (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Permanent Makeup / Micropigmentations:

___ Physician ___ Physician's Assistant ___ Nurse
___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(c) Have all staff performing Permanent Makeup / Micropigmentation treatments received a minimum of eight hours training including specific training for the equipment being used, skin typing, contraindications, potential complications, and performance of at least one procedure on a live patient? .....[ ] Yes [ ] No
If No, explain: _____

9. Sclerotherapy Injections

Does the Applicant perform Sclerotherapy Injections? .....[ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Sclerotherapy Injections: ..... (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Sclerotherapy Injections?

___ Physician ___ Physician's Assistant ___ Nurse
___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(c) Are all staff performing Sclerotherapy Injections physicians who have received a minimum of eight hours training specific for this procedure, including anatomy, physiology, technique, potential complications, appropriate responses to complications, and hands-on performance of a minimum of one procedure on a live patient? .....[ ] Yes [ ] No

10. Tattoo Removals

Does the Applicant perform Tattoo Removals? .....[ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of Tattoo Removals: ..... (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs Tattoo Removal:

___ Physician ___ Physician's Assistant ___ Nurse
___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

(c) Are all staff performing Tattoo Removal licensed physicians who comply with the following standards of practice:

(i) Physicians are trained appropriately in laser physics, tissue interaction, laser safety, clinical application, pre-operative care, and post-operative care of the laser patient. .....[ ] Yes [ ] No

(ii) Prior to the initiation of any patient care activity the physician has read and signed the clinic's policies and procedures regarding the safe use of lasers. .....[ ] Yes [ ] No

(iii) Continuing education of all physicians is mandatory and made available with reasonable frequency (including outside the office setting) to help insure adequate performance. (Specific credit hour requirements will be determined by the state and/or individual clinic.) .....[ ] Yes [ ] No

11. Surgical or Minor Surgical / Invasive Procedures

Does the Applicant perform surgical or minor surgical/invasive procedures? .....[ ] Yes [ ] No

If Yes, complete the following:

(a) Total number of surgical procedures: ..... (i) Past 12 months: _____ (ii) Next 12 months: _____

(b) Who performs surgical and/or minor surgical/invasive procedures?

_____

(c) Provide a complete list of all surgical and minor surgical/invasive procedures being performed:
Attach a separate sheet if necessary.

_____

Signing this Supplement does not bind the Company to provide or the Applicant to purchase the insurance.

It is understood that information submitted herein becomes a part of our application for insurance and is subject to the same declarations, representations and conditions.

Must be signed by director, executive officer, partner or equivalent within 60 days of the proposed effective date.

_____ _____
Name of Applicant Title (Officer, partner, etc.)

_____ _____
Signature of Applicant Date