

Brokerage: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Producer Name: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Broker Email: \_\_\_\_\_

**GENERAL INFORMATION**

Legal Business Name: \_\_\_\_\_  
 Location Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal: \_\_\_\_\_  
 Mailing (if different): \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ E-mail: \_\_\_\_\_ Website Address: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Fax#: \_\_\_\_\_ Res. #: \_\_\_\_\_ Cell #: \_\_\_\_\_

**Expiry Date of Policy:** \_\_\_\_\_

**Current Insurance Company:** \_\_\_\_\_ **Risk Ever Been Canceled:**  YES  NO  
**Target Premium: \$** \_\_\_\_\_ **# of years in business:** \_\_\_\_\_ **# of years of experience:** \_\_\_\_\_

**PLEASE PROVIDE A BROCHURE OF YOUR OPERATIONS WHEN YOU SUBMIT THIS APPLICATION**

Does the applicant currently carry Professional Liability insurance?  YES  NO  
 If yes, what is the retroactive date on the current Professional Liability policy? \_\_\_\_\_  
 Has the company had claims against them in last 5 years?  YES  NO  
 If yes, please explain: \_\_\_\_\_  
 Has the any staff (including contract staff) had claims against them in last 5 years?  YES  NO  
 If yes, please explain: \_\_\_\_\_

**PROPERTY INFORMATION**

Describe your location (Two storey, strip plaza, shopping mall, etc.) \_\_\_\_\_ No. of Stories: \_\_\_\_\_  
 Do you own the building?  YES  NO Total Area of your Facility: \_\_\_\_\_ Ft  
 The Building Age: \_\_\_\_\_ Latest Update: Roof \_\_\_\_\_ Heat \_\_\_\_\_ Plumbing \_\_\_\_\_ Electric \_\_\_\_\_  
 Fire Hydrants within 500 Feet?  YES  NO Restaurant within 2 adjacent units:  YES  NO Building Sprinklered?  YES  NO  
 Burglar Alarm?  Monitored  Local  NO Fire Alarm?  Monitored  Local  NO  
 Surveillance System?  YES  NO # of Fire Extinguishers: \_\_\_\_\_  
 Doors have deadbolts?  YES  NO Bars on Doors/Windows?  YES  NO  
 What is at - Front: \_\_\_\_\_ Back: \_\_\_\_\_ Left: \_\_\_\_\_ Right: \_\_\_\_\_  
 Construction of Building: \_\_\_\_\_  
 Loss Payee Information: (i.e.: bank financing, equipment leases, etc.) \_\_\_\_\_

**“PROPERTY VALUES” (IF YOU HAD TO REPLACE THE FOLLOWING ITEMS TODAY)**

Building (if required) \$ \_\_\_\_\_ Equipment \$ \_\_\_\_\_ Profits / BI \$ \_\_\_\_\_  
 Leasehold Improvements \$ \_\_\_\_\_ Stock \$ \_\_\_\_\_

**LIABILITY INFORMATION**

Are all inks/pigments from US or Canadian manufacturers?  YES  NO  
 Do you sell any inks/pigments?  YES  NO  
 Do you relabel or repackage any products?  YES  NO  
 Do you ever re-use needles?  YES  NO  
 Do you dispose of your pigments after each client?  YES  NO

**Description of Operations:** \_\_\_\_\_

**Liability Limits Desired:**  \$1,000,000  \$2,000,000  \$3,000,000  \$4,000,000  \$5,000,000

**NOTE:** we cannot offer coverage for the following services at this time. Please advise if these services are provided:

Physical Therapist on Staff	<input type="checkbox"/> YES <input type="checkbox"/> NO	Chiropractors on staff	<input type="checkbox"/> YES <input type="checkbox"/> NO
All Piercings other than Ear / Nose	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mole Removal – Invasive Cutting	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tattooing – Permanent Body	<input type="checkbox"/> YES <input type="checkbox"/> NO	Skin Tag Removal – Invasive Cutting	<input type="checkbox"/> YES <input type="checkbox"/> NO
Wart Removal – Invasive Cutting	<input type="checkbox"/> YES <input type="checkbox"/> NO		

**Basic Esthetics:**

Acid Peels less than 31% solution concentration	<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Estimated Gross Annual Receipts: \$</b> _____	
Acupuncture other than Moxibustion acupuncture	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hydrotherapy salt floatation chambers	<input type="checkbox"/> YES <input type="checkbox"/> NO
Acupressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hypnotherapy other than for past life regression and entertainment	<input type="checkbox"/> YES <input type="checkbox"/> NO
Aquatic massage beds	<input type="checkbox"/> YES <input type="checkbox"/> NO	Infrared Saunas and massage booths/beds	<input type="checkbox"/> YES <input type="checkbox"/> NO
Biofeedback therapy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Ionization detoxification	<input type="checkbox"/> YES <input type="checkbox"/> NO
Body wraps	<input type="checkbox"/> YES <input type="checkbox"/> NO	Iridology	<input type="checkbox"/> YES <input type="checkbox"/> NO
Brain wave harmony	<input type="checkbox"/> YES <input type="checkbox"/> NO	Make up – non permanent	<input type="checkbox"/> YES <input type="checkbox"/> NO
Cellulite treatment other than cellulite reduction weight loss	<input type="checkbox"/> YES <input type="checkbox"/> NO	Manicure/pedicures	<input type="checkbox"/> YES <input type="checkbox"/> NO
Colon irrigation	<input type="checkbox"/> YES <input type="checkbox"/> NO	Massage including relaxation massage, registered massage, reiki, reflexology, and aromatherapy, but does not include services to children under the age of 12 and Myofascial massage	<input type="checkbox"/> YES <input type="checkbox"/> NO
Dry Cupping – Wet Cupping is excluded	<input type="checkbox"/> YES <input type="checkbox"/> NO	Neuro emotional Clearing	<input type="checkbox"/> YES <input type="checkbox"/> NO
Dermaplanning	<input type="checkbox"/> YES <input type="checkbox"/> NO	NLP – NeuroLingulistic Programming	
Ear candling	<input type="checkbox"/> YES <input type="checkbox"/> NO	Nutritional consulting to follow the Canada Food Guide only	<input type="checkbox"/> YES <input type="checkbox"/> NO
Energy healing	<input type="checkbox"/> YES <input type="checkbox"/> NO	Oxygen treatments other than hyperbaric chambers	<input type="checkbox"/> YES <input type="checkbox"/> NO
Electrolysis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Piercing – ears and nose only	<input type="checkbox"/> YES <input type="checkbox"/> NO
EFT – Emotional Freedom Technique/Clearing	<input type="checkbox"/> YES <input type="checkbox"/> NO	Shamanic healing	<input type="checkbox"/> YES <input type="checkbox"/> NO
Eyebrow Tinting	<input type="checkbox"/> YES <input type="checkbox"/> NO	Spray tanning	<input type="checkbox"/> YES <input type="checkbox"/> NO
Facials	<input type="checkbox"/> YES <input type="checkbox"/> NO	Spray tattooing	<input type="checkbox"/> YES <input type="checkbox"/> NO
Glitter Tattooing – non permanent	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sugaring	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hair cutting and related service other than hair extension, wig/hair piece fitting/ sales	<input type="checkbox"/> YES <input type="checkbox"/> NO	Threading	<input type="checkbox"/> YES <input type="checkbox"/> NO
Henna Tattooing	<input type="checkbox"/> YES <input type="checkbox"/> NO	Toning beds	<input type="checkbox"/> YES <input type="checkbox"/> NO
High Intensity focused ultrasound (other than vaginal tightening and incontinence treatment)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Wart removal by solution only	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hydration machine	<input type="checkbox"/> YES <input type="checkbox"/> NO	Waxing	<input type="checkbox"/> YES <input type="checkbox"/> NO

**Mid-Range Esthetics**

Acid peels greater than 30% but less than 61% solution concentration	<input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Estimated Gross Annual Receipts: \$</b> _____	
Arasy machines	<input type="checkbox"/> YES <input type="checkbox"/> NO	Micropigmentation	<input type="checkbox"/> YES <input type="checkbox"/> NO
BB Glow	<input type="checkbox"/> YES <input type="checkbox"/> NO	Mole removal by solution only	<input type="checkbox"/> YES <input type="checkbox"/> NO
Body vibration fitness machines	<input type="checkbox"/> YES <input type="checkbox"/> NO	Myofascial massage	<input type="checkbox"/> YES <input type="checkbox"/> NO
Coolsculpting	<input type="checkbox"/> YES <input type="checkbox"/> NO	Oxygeneo	<input type="checkbox"/> YES <input type="checkbox"/> NO
Electrocoagulation	<input type="checkbox"/> YES <input type="checkbox"/> NO	Plasma-Pen	<input type="checkbox"/> YES <input type="checkbox"/> NO
EMS – Elector Muscular Stimulation including Acuscope and Myopulse	<input type="checkbox"/> YES <input type="checkbox"/> NO	Radio frequency treatments	<input type="checkbox"/> YES <input type="checkbox"/> NO
Endermologie	<input type="checkbox"/> YES <input type="checkbox"/> NO	Sclerotherapy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Fluid Isometrics	<input type="checkbox"/> YES <input type="checkbox"/> NO	Skin and micro needling	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hyaluron Pen	<input type="checkbox"/> YES <input type="checkbox"/> NO	Skin tag removal by solution or laser	<input type="checkbox"/> YES <input type="checkbox"/> NO
		Teeth whitening	<input type="checkbox"/> YES <input type="checkbox"/> NO

- |   |  |   |  |
|---|--|---|--|
| Laser/IPL/EPL/LHE various operations but not including laser treatments for purposes other than skin and hair treatment | <input type="checkbox"/> YES <input type="checkbox"/> NO | Thermolysis                                   | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| LILT & LLLT – low intensity laser therapy for weight reduction and gain, addictions, mental illness and pain reduction  | <input type="checkbox"/> YES <input type="checkbox"/> NO | Thermo-Lo                                     | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Micro current treatment   | <input type="checkbox"/> YES <input type="checkbox"/> NO | Vaginal Tightening and Incontinence Treatment | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Microdermabrasion   | <input type="checkbox"/> YES <input type="checkbox"/> NO | Vibrodermabrasion                             | <input type="checkbox"/> YES <input type="checkbox"/> NO |

**High End Esthetics:**

- |   |  |   |  |
|---|--|---|--|
| Cellulite reduction and body contouring and slimming by electronic device | <input type="checkbox"/> YES <input type="checkbox"/> NO | Estimated Gross Annual Receipts: \$ _____   |  |
| Bio resonance diagnostics   | <input type="checkbox"/> YES <input type="checkbox"/> NO | Tattoo removal by EliminiK  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Tattoo removal by Laser/IPL/EPL/LHE                                       | <input type="checkbox"/> YES <input type="checkbox"/> NO | Body injections for cosmetic purposes listed within our "injectable supplemental application" | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|   |  | Platelet Rich Plasma  | <input type="checkbox"/> YES <input type="checkbox"/> NO |

**Miscellaneous Professional Services:**

- |                    |  |  |  |
|--------------------|--|--|--|
| Brow Lamination    | <input type="checkbox"/> YES <input type="checkbox"/> NO | Estimated Gross Annual Receipts: \$ _____      |  |
| Eyelash Dipping    | <input type="checkbox"/> YES <input type="checkbox"/> NO | Microblading                                   | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Eyelash Extensions | <input type="checkbox"/> YES <input type="checkbox"/> NO | Tooth gems                                     | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Eyelash Tinting    | <input type="checkbox"/> YES <input type="checkbox"/> NO | Wigs and Extensions – Not attached by adhesive | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Hair Extensions    | <input type="checkbox"/> YES <input type="checkbox"/> NO | Latisse  | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Tanning – UV       | <input type="checkbox"/> YES <input type="checkbox"/> NO | Hollistic Vitamins                             | <input type="checkbox"/> YES <input type="checkbox"/> NO |

**Teaching Operations:**

- |   |  |   |  |
|---|--|---|--|
| Teaching and students offering service(s) to the public while under supervision | <input type="checkbox"/> YES <input type="checkbox"/> NO | Estimated Gross Annual Receipts: \$ _____ |  |
|---|--|---|--|

**Other Operations:**

- |  |                                |   |  |
|--|--------------------------------|---|--|
| <input type="checkbox"/> YES <input type="checkbox"/> NO | If yes, please describe: _____ | Estimated Gross Annual Receipts: \$ _____ |  |
|--|--------------------------------|---|--|

**WET AREAS**

- |   |  |                            |  |
|---|--|----------------------------|--|
| Diving Boards                             | <input type="checkbox"/> YES <input type="checkbox"/> NO | # of Swimming Pools? _____ |  |
| Are there any Slides                      | <input type="checkbox"/> YES <input type="checkbox"/> NO |                            |  |
| Chemicals Tested Daily                    | <input type="checkbox"/> YES <input type="checkbox"/> NO |                            |  |
| Hot Tub / Whirl Pool / Sauna / Steam Room | <input type="checkbox"/> YES <input type="checkbox"/> NO | # of units _____           |  |

**ADDITIONAL INFORMATION**

- |                              |  |  |  |
|------------------------------|--|--|--|
| Do you use a deep fat fryer? | <input type="checkbox"/> YES <input type="checkbox"/> NO | Do you ever serve alcohol as part of your service? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Snack Bar on Premises?       | <input type="checkbox"/> YES <input type="checkbox"/> NO | Do you rent space to associated businesses?        | <input type="checkbox"/> YES <input type="checkbox"/> NO |

**If yes, Please describe:**

- |  |  |
|--|--|
| Do you bring any specialists into your premise to provide additional operations? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|--|--|

**If yes, Please describe:**

- |  |  |
|--|--|
| Are there any operations or activities away from the premises? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|--|--|

**If yes, Please describe:**

- |   |  |
|---|--|
| Do you provide any permanent hair straightening operations? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|---|--|

**If yes, please provide name of products used:**

- |   |  |
|---|--|
| Please confirm if any of these products contain any formaldehyde? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
|---|--|

**Please describe your sterilization / cross-contamination prevention procedures:**

**Are any of the following operations conducted?**

- Massage - Registered  YES  NO → If yes, please **complete the Massage Supplementary application**
- Tanning Beds & Booths  YES  NO → If yes, please **complete the Tanning Supplementary application**
- Laser / IPL Treatment  YES  NO → If yes, please **complete the Laser / IPL Supplementary application**
- Injectable Services  YES  NO → If yes, please **complete the Injectable Supplementary application**
- Teaching Operations  YES  NO → If yes, please **complete the Teaching Supplementary application**
- Teeth Whitening  YES  NO → If yes, please **complete the Teeth Whitening Supplementary application**
- Platelet-rich Plasma  YES  NO → If yes, please **complete the Platelet-rich Plasma(PRP) Supplementary application**
- Plasma Pen  YES  NO → If yes, please **complete the Plasma Pen Supplementary application**

**Full Time / Contract Employee Information:**

# of **Full time (F/T)** Employees? \_\_\_\_\_ # of **Part time (P/T)** Employees? \_\_\_\_\_  
 # of **Contract** People? \_\_\_\_\_

NAME	YEARS OF EDUCATION	YEARS OF EXPERIENCE	OPERATIONS OF EACH INDIVIDUAL	F/T, P/T OR CONTRACT	CERTIFICATION ATTACHED?

- **ADDITIONAL INSURED** (i.e.: landlord)

**\*\* CYBER LIABILITY \*\***

- Does the Company store any medical/health information for clients?  YES  NO
- If yes, does the Company follow the minimum standards under the HIPAA (encryption and firewalls in place)?  YES  NO
  - If yes, does the Company follow the minimum standards under PIPEDA or the respective PIPA requirements (encryption and firewalls in place)?  YES  NO
  - Higher cyber limits may be available, please contact your underwriter for details.

**PLEASE READ BEFORE SIGNING:** A claim will become invalid and the Insured's right of recovery is forfeited where (a) an Applicant for this contract gives false particulars to the prejudice of the insurer or knowingly misrepresents or fails to disclose any fact in any part of this application required to be stated therein; or (b) the insured fails to inform material changes to these facts during the term of the contract; (c) the insured contravenes a term of the contract or commits a fraud; or (d) the insured willfully makes a false statement in respect of a claim.

The Applicants have reviewed all parts and attachments of this application and acknowledge that all information is true and correct and understand that this application for insurance is based on the truth and completeness of this information.

The personal information provided in this document and in the future including, but not limited to, credit information and claims history may be collected, used and disclosed by the insured's representative or insurance company, subject to local legislation, for the purpose of communicating with the insured or their representative, assessing the application for insurance and underwriting any such policies, evaluating claims, detecting and preventing fraud, and analyzing business results. I confirm that all individuals whose personal information is contained in this document have authorized that I agree to the above on their behalf.

**NOTE: Insurance is not in effect until Premier has issued a binder or policy documents.**

Insured Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Broker Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Broker Email: \_\_\_\_\_

*Premier Canada Assurance Managers Ltd. is one of Canada's largest Managing Underwriting Agents. The underwriting insurance carrier varies by line of business and region - please refer to specific quote for declaration of the underwriting insurance company(s).*

\*\* Email application and attachments to - [newbizcommercial@premiergroup.ca](mailto:newbizcommercial@premiergroup.ca) \*\*

Vancouver - T 604.669.5211 F 604.669.2667      London - T 519.850.1610 F 519.850.1614

**MESSAGE SUPPLEMENTARY APPLICATION**

Please complete this section for all Massage Therapists on Staff:

NAME OF MASSAGE THERAPIST	TYPE(S) OF MASSAGE THEY PERFORM (please list all)	YEARS OF EDUCATION	YEARS OF EXPERIENCE	ARE YOU AN RMT?	
				YES	NO
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

- 1 Do you collect and discuss the client's health information?  YES  NO
- 2 Is a waiver signed, dated and kept on record? (\*\*Must be kept on file for min. 7 years)  YES  NO
- 3 Do you offer massages to infants?  YES  NO
- 4 Have any of the masseuses listed above had a claim made against them?  YES  NO
- If so, please advise:

**TANNING SALON SUPPLEMENTARY APPLICATION**

**LIABILITY INFORMATION – Limits will be the same as the main operations that you have provided.**

<u>EQUIPMENT INFORMATION</u>	Age	# of Units	Type of Timer (digital, coin, token, manual, etc.)
<b>BEDS</b>			
<b>BOOTHS</b>			
<b>SPRAY BOOTHS</b>			
<b>AIR BRUSH</b>			

Who Changes the Bulbs?

- Is there any massage offered  YES  NO Are clients given tanning instructions?  YES  NO
- Do all client sign waivers?  YES  NO Do all clients complete skin analysis?  YES  NO
- Do any beds operate by tokens?  YES  NO Do any beds operate by coins?  YES  NO
- Are clients required to wear goggles?  YES  NO Are signs posted to wear goggles?  YES  NO
- Does the sign in sheet that clients initial prior to each session state that "Clients Must Wear Eye Goggles"?  YES  NO
- Are the Tanning Staff Smart Tan or Equivalent Certified?  YES  NO
- Is Equipment Inspected and Cleaned After Each Use?  YES  NO
- Who sets the amount of time a client is able to tan on each bed?  CLIENT or  STAFF
- Where is the timer located, which sets the amount of time a client tan?  FRONT DESK or  BED
- Are tanning sessions and waiver records saved and filed for NO less than 2 years?  YES  NO
- Is the tanning salon listed as a full member of Smart Tan Canada?  YES  NO
- So the insured does not have to send us a copy of all Smart Tan certifications and a copy of their membership ---
- Please check "YES" so that we can confirm this information with Smart Tan Canada  YES  NO
- (Premium advantages if each salon location is listed as a Smart Tan Member – Ask us if salons are not members)
- Do you rent space to others within your unit?  YES  NO If yes, do they list you as an additional insured?  YES  NO
- If yes, please advise name of lessee:

**LASER SUPPLEMENTARY APPLICATION**

★PLEASE COMPLETE ALL QUESTIONS★

★IF YOU REQUIRE ADDITIONAL SPACE, PLEASE ADD ADDITIONAL PAGES AS NECESSARY★

Please advise IF and HOW you provide the following operations (Please check all lines of operations):

SERVICE	LASER		PULSE LIGHT/IPL	
	YES	NO	YES	NO
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endovenous Laser Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leg Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis & Vitiligo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Resurfacing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cosmetic Re-pigmentation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair Removal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pigmented Lesions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Lesions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cellulite Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please describe):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**\*\*Please provide all operators who provide laser treatment or cellulite treatment and their experience:**

NAME PERSON PROVIDING LASER TREATMENT	YEARS OF EDUCATION	YEARS EXPERIENCE/ QUALIFICATION	ANY PRIOR CLAIMS MADE AGAINST EACH INDIVIDUAL (PLEASE GIVE BRIEF DETAILS)

**\*\*Complete this section for all laser/cellulite machines (please list additional hand pieces separately):**

MAKE	MODEL	AGE	CURRENT REPLACEMENT COST IN CANADIAN \$\$
		Yrs.	\$
		Yrs.	\$
		Yrs.	\$
		Yrs.	\$
		Yrs.	\$
		Yrs.	\$
		Yrs.	\$
		Yrs.	\$

Please answer all questions:

- Please circle what skin types you provide services on for the laser treatments:  
As per the Fitzpatrick Scale: 1  2  3  4  5  6
- Do you complete a skin patch test prior to laser treatments?  YES  NO
- How long do you wait after the patch test to perform laser treatment?
- Do you wear surgical gloves when providing laser services to clients?  YES  NO
- Does your client wear protective eyewear during laser services?  YES  NO
- Do you keep copies of all client service records? (\*\*Must be kept on file for min. 7 years)  YES  NO
- Is a waiver signed, dated and kept on record? (please attach a copy)  YES  NO
- Do you explain to the client what steps to take prior to any laser treatment?  YES  NO  
Please describe:
- Do you explain to the client what steps to take after any laser treatment?  YES  NO  
Please describe:
- How often do you calibrate your machines?
- Do you provide any off-site laser treatments?  YES  NO  
If yes, list all locations, methods of transporting equipment and frequency of all off-site treatments:

**INJECTABLE SUPPLEMENTAL APPLICATION**

Please Complete this section for ALL people performing Injectable services:

RPN = REGISTERED PRACTICAL NURSE    RN = REGISTERED NURSE    NP = NURSE PRACTITIONER    D = DOCTOR

NAME	YEARS OF EDUCATION	YEARS OF EXPERIENCE	DO THEY HAVE OWN INSURANCE FOR THIS SERVICE	PROVIDE DESIGNATION AS ABOVE	ADVISE FT, PT, OR CONTRACT

**PLEASE CHECK APPLICABLE SERVICES & ADVISE WHO PERFORMS SERVICE (RPN, RN, NP, D – AS NOTED ABOVE)**  
 \*\*\* Means this injection must be performed by Doctor

<input type="checkbox"/> Aquamid***	<input type="checkbox"/> Belkyra Deoxycholic	<input type="checkbox"/> Belotero Balance***
<input type="checkbox"/> Bio-Alcamid***	<input type="checkbox"/> Bioinblue	<input type="checkbox"/> Botox – Vistabel
<input type="checkbox"/> Botox/Dysport/Xeomin/ Azzalure/Neurobloc Bocouture	<input type="checkbox"/> Dermadeep***	<input type="checkbox"/> Dermalive
<input type="checkbox"/> Elastence	<input type="checkbox"/> Emervel Lips/Volume Classic	<input type="checkbox"/> Esthelis Basic/Soft/Glycerol
<input type="checkbox"/> Evolence	<input type="checkbox"/> Evolution***	<input type="checkbox"/> Hydra-Fill 1/2/3/Softline/Softline Max
<input type="checkbox"/> Hylaform / Finline / Plus	<input type="checkbox"/> IAL-System	<input type="checkbox"/> Juvederm Ultra (24)
<input type="checkbox"/> Juvederm Ultra XC	<input type="checkbox"/> Juvederm Ultra Plus (30)	<input type="checkbox"/> Juvederm Ultra Plus XC
<input type="checkbox"/> Juvederm Refine	<input type="checkbox"/> Juvederm Volift/Volbella	<input type="checkbox"/> Juvederm Vollure XC
<input type="checkbox"/> Laresse	<input type="checkbox"/> Matridex***	<input type="checkbox"/> Matridur
<input type="checkbox"/> Nuceiva	<input type="checkbox"/> Outline	<input type="checkbox"/> Phiderma SR
<input type="checkbox"/> Princess Volume / Princess Fillers	<input type="checkbox"/> Puragen / Puragen Plus	<input type="checkbox"/> Radiesse
<input type="checkbox"/> RAVENESSE	<input type="checkbox"/> RAVENESSE Ultra	<input type="checkbox"/> Redexis
<input type="checkbox"/> Redexis Ultra***	<input type="checkbox"/> Restylane/Touch/Perlane/Lipp (Restylane Lidocaine/Vital)	<input type="checkbox"/> Restylane Lip Volume / Refresh
<input type="checkbox"/> Restylane SubQ / Restylane Lyft / Restylane Kysse / Restylane Refyne / Restylane Defyne / Restylane Volyme / Restylane Skin Boosters	<input type="checkbox"/> Reviderm Intra***	<input type="checkbox"/> Sculptra (Poly L Lactic Acid)
<input type="checkbox"/> Stylage(S/M/L/XL/Special Lips/Hydromax)	<input type="checkbox"/> Surgiderm 18/24XP/30/30XP/Surgilips	<input type="checkbox"/> Surgilift Plus
<input type="checkbox"/> Teosyal Global Action/Touch Up/First Lines/Deep Lines/Kiss/Ultra Deep/Pure Sense/Redensity	<input type="checkbox"/> Teosyal Voluma	<input type="checkbox"/> Teoyal Pure Sense Ultimate
<input type="checkbox"/> Voluma	<input type="checkbox"/> Viscontour	<input type="checkbox"/> Zyderm 1/2/Zyplast
<input type="checkbox"/> Mesotherapy	<input type="checkbox"/> Platelet Rich Plasma <i>Please have PRP Supplemental Application completed</i>	

List any other injections offered that are not noted above: \_\_\_\_\_

Has the company had claims against them in the last 5 years?  YES  NO

Has any staff (including contract staff) had claims against them in the last 5 years?  YES  NO

**If yes to either of the above questions, please list full details on the cover page.**

**TEACHING SUPPLEMENTAL APPLICATION**

Legal Business Name:

Name	Person Instructing Class	Certified to teach	Years providing service	Any prior claims

Is the applicant/insured certifying students?  YES  NO

**HEALTH & WELLNESS PROGRAM - FULL SPA OPERATIONS APPLICATION**

Can someone without any esthetics experience take a course?  YES  NO

Is there additional training offered to students without prior esthetics?  YES  NO

List all courses offered:

Number of Students per year?

Number of hours students complete prior to graduations?

Is the final exam proctored by the provincial regulator?  YES  NO

Do students offer services to the public:  YES  NO

If yes, 1. the number of hours completed prior to offering any services to the public:

2. Do all clients sign a waiver holding the school and student harmless?  YES  NO

3. Are the students supervised at all times when offering service to the public?  YES  NO

4. Do students offer Micropigmentation services to the public?  YES  NO

5. Do students offer Laser/IPL services to the public?  YES  NO

6. Do students offer Body Injection services to the public?  YES  NO

7. Does the applicant teach Platelet Rich Plasma (PRP) services to the public?  YES  NO

8. Does the applicant teach Plasma Pen services to the public?  YES  NO

**ESTIMATED ANNUAL GROSS RECEIPTS:**

Public Services by Students \$ \_\_\_\_\_

Public Services by Non Students \$ \_\_\_\_\_

Tuition Fees \$ \_\_\_\_\_

**Total Yearly Teaching Receipts Gross Sales & Operation Receipts \$ \_\_\_\_\_**

**TEETH WHITENING SUPPLEMENTAL APPLICATION**

1. Does all staff wear sterilized gloves when performing services?  YES  NO

2. Is the product manufactured in North America?  YES  NO

If no, where?

Is it approved for use by Health Canada  YES  NO

3. Do all clients sign a hold harmless agreement or a consent form prior to offering service the first time?  YES  NO

4. Do you manufacture or fit any Teeth whitening appliance for client?  YES  NO

5. Maximum % of Carbomide Solution Used:

6. Maximum % of Hydrogen Peroxide Solution Used:

7. Please advise length solution is kept on teeth:

8. Please advise number of treatments in 1 visit:

9. Have you ever had a claim made against you?  YES  NO

If yes, please advise:

Name Brand of teeth whitening product used:

**PLATELET-RICH PLASMA(PRP) SUPPLEMENTAL APPLICATION**

1. Receipts from Applicant's operations:

Last 12 months (expiring)	Next 12 months (expiring)

2. What PRP services are offered? Check all that apply:

<input type="checkbox"/> Hair Restoration	<input type="checkbox"/> Vampire Facials with Skin & Micro needling – excludes facelifts
<input type="checkbox"/> Vaginal Rejuvenation – O Shots	<input type="checkbox"/> Neck Rejuvenation
<input type="checkbox"/> Cellulite <b>Reduction</b>	<input type="checkbox"/> Erectile Dysfunction – P Shots



HEALTH & WELLNESS PROGRAM - FULL SPA OPERATIONS APPLICATION

<input type="checkbox"/> PRP with Body Injections (i.e. Dermal Filler) <b>** Injectable supplement application required</b>	<input type="checkbox"/> Teaching / certifying others in PRP <b>** Teaching application required</b>
<input type="checkbox"/> Other PRP Services, please list:	

3. Please provide list of names of ALL employees & sub-contractors who perform PRP services:

NAME PERSON PROVIDING PRP TREATMENT	PRP SERVICES PERFORMED	YEARS OF EXPERIENCE / EDUCATION FOR PRP	ATTACH / LIST ALL CERTIFICATIONS / QUALIFICATIONS	IS THIS PERSON: RN = REGISTERED NURSE NP = NURSE PRACTITIONER RPN = REGISTERED PRACTICAL NURSE D = DOCTOR O = OTHER (PLEASE LIST)

**Claims History:**

4. Has the company had claims against them in the last 5 years? Y  N

5. Has any staff (including contract staff) had claims against them in the last 5 years? Y  N

If yes to either of the above questions, please list full details.  
Full Claims Information: \_\_\_\_\_  
\_\_\_\_\_

**PLASMA PEN SUPPLEMENTAL APPLICATION**

1. What Plasma Pen services are offered? Check all that apply:

<input type="checkbox"/> Skin Tightening	<input type="checkbox"/> Tattoo Removal/lightening <b>**Unable to Offer Coverage</b>
<input type="checkbox"/> Skin tag removal	<input type="checkbox"/> Mole removal – sign off by a doctor required
<input type="checkbox"/> Cellulite Reduction	<input type="checkbox"/> Teaching/certifying others in Plasma Pen (min. 1 year of plasma pen experience) <b>**Teaching application required</b>
<input type="checkbox"/> Other (please list all other services offered):	

2. What skin types for you provide services on for Plasma Pen Operations? (Check all that apply)

As per the Fitzpatrick Scale:  1  2  3  4  5\*\*  6\*\*

**\*\*Unable to Offer Coverage if services are provided to skin types 5&6**

3. Are waivers and service records signed, dated and kept on file for at least 7 years?  YES  NO

4. Do you provide after care instructions? (Please provide a copy)  YES  NO

5. Please provide the following information regarding the plasma pen/machine used:

MAKE	MODEL	COUNTRY OF ORIGIN	SERVICES PERFORMED	FDA/HEALTH CANADA APPROVED?

6. Please provide the names of ALL employees & sub-contractors who perform Plasma Pen Services

NAME PERSON PROVIDING PLASMA PEN TREATMENT	PLASMA PEN SERVICES PERFORMED	YEARS EXPERIENCE/ EDUCATION FOR PLAMA PEN	YEARS OF BEAUTICIAN RELATED EXPERIENCE	IS THIS PERSON: RN = REGISTERED NURSE NP = NURSE PRACTITIONER RPN = REGISTERED PRACTICAL NURSE D = DOCTOR O = OTHER (PLEASE LIST)

**Claims History:**

7. Has the company had claims against them in the last 5 years?  YES  NO

8. Has any staff (including contract staff) had claims against them in the last 5 years?  YES  NO

If yes to either of the above questions, please list full details on the cover page.