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## SUPPLEMENT FOR MEDICAL SPA/ANTI-AGING CLINICS

**Use with Application for Clinics Professional Liability Insurance MASM 5004.**

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:

| | | | |
|---|---|---|---|
| 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:
   a. Screen each patient for existing and prior medical conditions prior to treatment? ..... [ ] Yes [ ] No
   b. Discuss procedural risks with all clients prior to treatment? ..... [ ] Yes [ ] No
   c. Obtain signed and dated informed consent from all patients prior to commencing treatment? ..... [ ] Yes [ ] No
      Please provide a copy of the informed consent form.
   d. Perform services on clients under the age of 18? ..... [ ] Yes [ ] No

If Yes, is written parental/guardian consent obtained before performing any procedure? ..... [ ] Yes [ ] No

e. Maintain patient treatment records? ..... [ ] Yes [ ] No

If Yes, how long are patient treatment records kept? _____

f. Perform services on pregnant women? ..... [ ] Yes [ ] No

If Yes, what services are performed? _____

g. Use disposable gloves (latex or non-latex) in your procedures? ..... [ ] Yes [ ] No

h. For the categories listed below, please identify the method(s) of cleaning, disinfection or sterilization employed in your practice:

| | Sterilized* | Disinfected** | Cleaned*** | Disposable |
|---|---|---|---|---|
| Needles | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No |
| Equipment/Instruments used to penetrate the skin | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No |
| Jewelry/Ornaments | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No |
| Furniture/Floors | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No |
| Staff/Patient Garments | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No |
| Other Articles _____ | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No | [ ] Yes<br>[ ] No |

* Subjected to a process that eliminates all forms of microorganisms, e.g. autoclave

** Subjected to a process that eliminates many or all pathogenic microorganisms, except bacterial spores, on inanimate objects, e.g. use of alcohol, peroxide, bleach, etc.

*** Subjected to manual or mechanical removal of visible soil using water and detergent or other enzymatic product

i. For any of the Section IV. Procedures below, provide clients with written aftercare instructions? ..... [ ] Yes [ ] No

Please provide a copy of the aftercare instructions.

j. Take before and after pictures of every patient? ..... [ ] 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

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: _____

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

If No, explain. _____

6. Mesotherapy/Injection Lipolysis/Cryolipolysis

Does the Applicant perform Mesotherapy/Administration of Injection Lipolysis Mixtures/Cryolypolisis at this clinic? [ ] Yes [ ] No

If Yes, complete the following:

a. Total number of Mesotherapy/Injection Lipolysis/Cryolypolosis Treatments:

i. Past 12 months: _____ ii. Next 12 months: _____

b. Are all staff performing Mesotherapy/administration of Injection Lipolysis and/or Cryolipolysis treatments licensed physicians with a minimum of eight hours training to perform Mesotherapy/ injection lipolysis and/or cryolipolysis treatments 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 / Tattoos / Body Piercings

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

If Yes, complete the following:

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

Total number of Tattoos: ..... i. Past 12 months: _____ ii. Next 12 months: _____

Total number of Body Piercings: ..... i. Past 12 months: _____ ii. Next 12 months: _____

b. Who performs Permanent Makeup / Micropigmentations / Tattoos / Body Piercing?:

___ Physician ___ Physician's Assistant ___ Nurse

___ Dentist ___ Nurse Practitioner ___ Other-describe: _____

c. Has the Applicant performing Permanent Makeup / Micropigmentation / Tattoos / Body Piercing 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: _____

d. Does the Applicant's practice include piercings of the following:

Head? ..... [ ] Yes [ ] No

Torso? ..... [ ] Yes [ ] No

Hands/Feet? ..... [ ] Yes [ ] No

Genitalia? ..... [ ] Yes [ ] No

e. What certificates in professional training are held by the person(s) performing the procedures identified in 8. a. above? _____

_____

Please include a copy(ies) of the certificate(s).

f. Are all instruments and articles that are intended to penetrate the skin sterilized before and after use? ..... [ ] Yes [ ] No

How are instruments/equipment sterilized?) _____

g. Are instruments or articles that are intended to penetrate the skin cleaned with chemical disinfectants? ..... [ ] Yes [ ] No

h. Are any instruments stored in disinfectant before or after cleaning or sterilizing? ..... [ ] Yes [ ] No

i. Do any tattoo inks utilized in your practice contain paraphenylenediamine (**PPD**) or black henna? ..... [ ] Yes [ ] No

j. Is the ink utilized in your practice only manufactured with sterilized water? ..... [ ] Yes [ ] No

k. Does the Applicant:

i. only utilize sterile water for the purpose of diluting tattoo ink? ..... [ ] Yes [ ] No

ii. only use non-toxic metals used for body piercing? ..... [ ] Yes [ ] No

iii. perform piercings with a piercing gun? ..... [ ] Yes [ ] No

l. Is tattoo removal performed by other than a medical doctor? ..... [ ] Yes [ ] No

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. Are all staff performing Sclerotherapy Injections licensed physicians? ..... [ ] Yes [ ] No

10. Radio-Frequency or Ultrasound Energy Heat Treatments

Does the Applicant perform Radio-Frequency or Ultrasound Energy Heat Treatments solely for cosmetic purposes? ..... [ ] Yes [ ] No

If No, for what purpose(s) are these treatments performed? _____

a. Total number of Heat Treatments: ..... i. Past 12 months: _____ ii. Next 12 months: _____

b Who performs Heat Treatments?

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

c. Have all staff performing Radio-Frequency or Ultrasound Energy Heat Treatments received a minimum of eight hours training to perform Radio-Frequency or Ultrasound Energy Heat Treatments by the equipment manufacturer? ..... [ ] Yes [ ] No

If No, what training has been undertaken? _____

11. 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. 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

12. 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