

INSTRUCTIONS

Complete all sections in full and attach to the main Allied Healthcare & Medical Malpractice application. Incomplete submissions may delay quoting or result in exclusions.

SECTION A — CLINIC / STUDIO DETAILS

LEGAL / OPERATING NAME		LICENCE / PERMIT NUMBER (IF APPLICABLE)	
<input type="text"/>		<input type="text"/>	
BUSINESS ADDRESS	CITY	PROVINCE / STATE	POSTAL / ZIP
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
PRIMARY CONTACT NAME	PHONE	EMAIL	YEAR ESTABLISHED
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
# OF CLINIC LOCATIONS COVERED	TOTAL # OF LASER / IPL OPERATORS	ESTIMATED ANNUAL # OF TREATMENTS	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

SECTION B — SERVICES & DEVICES

TREATMENT TYPES OFFERED (CHECK ALL THAT APPLY)

- | | |
|--|--|
| <input type="checkbox"/> Laser hair removal | <input type="checkbox"/> IPL hair removal |
| <input type="checkbox"/> Laser tattoo removal | <input type="checkbox"/> Skin rejuvenation / resurfacing |
| <input type="checkbox"/> Vascular / redness treatments | <input type="checkbox"/> Pigmentation / age spot removal |
| <input type="checkbox"/> Acne / acne scar treatment | <input type="checkbox"/> RF / HIFU skin tightening |
| <input type="checkbox"/> Permanent makeup removal | <input type="checkbox"/> Photodynamic therapy (PDT) |
| <input type="checkbox"/> CO2 / ablative resurfacing | <input type="checkbox"/> Other (describe below) |

IF 'OTHER', DESCRIBE TREATMENTS PROVIDED

Are any treatments provided on referral from a medical professional, or billed as a medical / therapeutic service? Yes No

IF YES — DESCRIBE NATURE OF MEDICAL REFERRALS / THERAPEUTIC TREATMENTS

DEVICE TYPES IN USE (CHECK ALL THAT APPLY)

- | | |
|---|--|
| <input type="checkbox"/> Diode laser | <input type="checkbox"/> Nd:YAG laser |
| <input type="checkbox"/> Alexandrite laser | <input type="checkbox"/> Ruby laser |
| <input type="checkbox"/> CO2 laser | <input type="checkbox"/> Er:YAG laser |
| <input type="checkbox"/> IPL (intense pulsed light) | <input type="checkbox"/> RF (radiofrequency) |
| <input type="checkbox"/> HIFU (high-intensity focused ultrasound) | <input type="checkbox"/> Picosecond laser |
| <input type="checkbox"/> Other (describe below) | |

IF 'OTHER', DESCRIBE DEVICE TYPE(S)

SECTION B — SERVICES & DEVICES (continued)
DEVICE DETAILS

DEVICE MAKE / MODEL	TREATMENT TYPE	COUNTRY OF MANUFACTURE	YEAR OF MANUFACTURE	LAST SERVICED

CONFIRM ALL — tick to confirm YES to each statement. Indicate any NO answers in the field provided.

- All devices are approved by Health Canada (or equivalent regulatory authority) for the treatments being performed.
 - All devices are calibrated in accordance with manufacturer specifications and applicable regulations.
 - Formal written training from the device manufacturer or authorised supplier has been completed by all operators for each device they use.
 - Proof of manufacturer / supplier training is retained on file for all operators.
- Confirmed — all statements above apply to this clinic / studio.

IF ANY STATEMENT ABOVE DOES NOT APPLY — EXPLAIN HERE

DEVICES OVER 8 YEARS OLD

Does the clinic operate any laser or IPL device that is more than 8 years old? Yes No

If yes — has each device over 8 years old been inspected and serviced by a qualified technician within the last 6 months? Yes No N/A

SECTION C — OPERATOR QUALIFICATIONS

List all laser / IPL operators performing treatments at or on behalf of the clinic.

OPERATOR NAME	CERTIFICATION / LICENCE HELD	ISSUING BODY	EXPIRY DATE	DEVICES OPERATED

CONFIRM ALL — tick to confirm YES to each statement. Indicate any NO answers in the field provided.

- All laser / IPL operators hold a current, recognized laser safety or operator certification.
 - All operators perform treatments only within the scope of their certification.
 - Certification records are retained on file and renewed prior to expiry.
 - All operators have received formal written training from the device manufacturer or authorised supplier for each specific device they operate.
- Confirmed — all statements above apply to this clinic / studio.

IF ANY STATEMENT ABOVE DOES NOT APPLY — EXPLAIN HERE

SECTION D — CLIENT SCREENING & PROTOCOLS

CONFIRM ALL — tick to confirm YES to each statement. Indicate any NO answers in the field provided.

- A Fitzpatrick skin type assessment is conducted on all clients prior to treatment.
 - Treatment parameters (wavelength, fluence, pulse duration) are adjusted based on the client's Fitzpatrick skin type.
 - A patch test is performed on all new clients prior to their first treatment.
 - A separate patch test is performed on each distinct treatment area prior to treating that area.
 - A contraindication screening questionnaire is completed by all clients prior to each treatment.
 - Clients with active skin conditions or open lesions in the treatment area are excluded.
 - Appropriate laser-rated eye protection goggles are provided to all clients during treatments.
 - All operators wear appropriate laser-rated eye protection during all treatments.
- Confirmed — all statements above apply to this clinic / studio.

IF ANY STATEMENT ABOVE DOES NOT APPLY — EXPLAIN HERE

SECTION D — CLIENT SCREENING (continued)

TREATMENT AREAS

SENSITIVE / RESTRICTED TREATMENT AREAS PERFORMED (CHECK ALL THAT APPLY)

- | | |
|---|--|
| <input type="checkbox"/> Full face | <input type="checkbox"/> Periorbital (around eyes) |
| <input type="checkbox"/> Neck / décolletage | <input type="checkbox"/> Intimate / genital area |
| <input type="checkbox"/> Breast | <input type="checkbox"/> None of the above |

If intimate / genital treatments are performed — do all operators have documented specialized training for this area? Yes No N/A

MINORS

- Does the clinic perform laser / IPL treatments on minors (under 18)? Yes No
- Is written parental / guardian consent obtained prior to any treatment on a minor? Yes No N/A
- Are consent forms and waivers for minors retained until the individual reaches the age of majority? Yes No N/A

SECTION E — CONSENT, WAIVERS & RECORDS

CONFIRM ALL — tick to confirm YES to each statement. Indicate any NO answers in the field provided.

- Written informed consent is obtained from all clients prior to every treatment.
 - Consent forms detail all associated risks, potential side effects, and contraindications.
 - Aftercare guidance is provided to all clients following every treatment, verbally and in writing.
 - All consent forms and waivers are signed and dated by the client at the time of each treatment.
 - Client consent forms, waivers, patch test results, and treatment records are retained on file for a minimum of 10 years.
 - Client records are stored securely in compliance with applicable privacy legislation.
- Confirmed — all statements above apply to this clinic / studio.

IF ANY STATEMENT ABOVE DOES NOT APPLY — EXPLAIN HERE

SECTION F — ADVERSE EVENTS & CLAIMS HISTORY

ADVERSE EVENTS

Has any laser / IPL treatment resulted in an adverse event (e.g. burn, blister, scarring, pigmentation change)? Yes No
 Is a formal adverse event protocol in place and communicated to all operators? Yes No
 Are all adverse events documented and retained on file? Yes No

IF ADVERSE EVENTS HAVE OCCURRED — DESCRIBE NATURE, FREQUENCY, AND OUTCOME(S)

CLAIMS HISTORY

Has the clinic, any entity, or any individual operator ever been subject to a claim, complaint, suit, or demand for compensation arising from laser / IPL treatments? Yes No

DATE	NATURE OF CLAIM / COMPLAINT	TREATMENT / DEVICE INVOLVED	STATUS	PAID (\$)	RESERVED (\$)

Are there any known circumstances that may give rise to a future claim or complaint? Yes No

IF YES — DESCRIBE IN FULL DETAIL

SECTION G — DECLARATIONS & AUTHORIZED SIGNATURE

IMPORTANT NOTICE

The information provided in this supplementary application forms part of any policy issued and must be read together with the main application. The applicant warrants that all statements are true, accurate, and complete to the best of their knowledge. Material misrepresentation or omission may render any policy issued voidable at the option of the insurer.

FULL NAME (PRINT)	TITLE / POSITION	DATE (MM / DD / YYYY)
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SIGNATURE OF AUTHORIZED REPRESENTATIVE