Supplemental Questionnaire: **MediSpa Services**

Instructions:

1. This application must be completed in conjunction with the Pro-Praxis Allied Healthcare Application.
2. Answer ALL questions completely, leaving No blanks. If any questions, or part thereof, do not apply, print "n/a" in the appropriate space. Any spaces left blank will be interpreted to not apply.
3. This application must be completed, dated and signed by a Principal or Officer of your firm. Underwriters will rely on all statements made in this application.

Applicant Name: _____

1. Is your business ownership:
   ☐ Physician Owned ☐ Hospital Owned ☐ Independently Owned
   ☐ Other (specify): _____

   If you perform a procedure that is called by a different name, but essentially the same as any of the below procedures, please answer the question accordingly.
   If you perform procedures other than those shown below, please attach a list of those procedures and the number of anticipated patient encounters for the next 12 months.

2. Please provide the estimated number of procedures that will be performed over the next 12 months?

_____ Acne Treatment	_____ Acupuncture
_____ BOTOX	_____ Brown Spot Removal
_____ Chemical Peels (Light)	_____ Chemical Peels (Medium-Heavy) Strength _____
_____ Collagen Injections	_____ Dermal Fillers
_____ Dermaplaning	_____ Ear Candling
_____ Electrolysis	_____ Hyperbaric Treatment
_____ Laser Cellulite Treatment	_____ Laser Hair Removal
_____ Laser Skin Resurfacing	_____ Mesoderm
_____ Mesotherapy	_____ Microdermabrasion
_____ Permanent Makeup	_____ Photo Facial Rejuvenation (IPL)
_____ Pigmented Lesion Removal	_____ Sclerotherapy
_____ Skin Tag Removal	_____ Tattoo Removal
_____ Teeth Whitening	_____ Thermage
_____ Vein Treatment	_____ Wart Removal
_____ Weight Loss Management	_____ Other (specify): _____

   *_____ TOTAL # of procedures for the next 12 months *(should be total of all the above)*

3. For the following procedures, please provide additional information requested?

# Per Year Procedure	**Who Performs the Procedure**
_____ Vein Treatment	
_____ Hair Transplant	
_____ Lipo Dissolve	
_____ Lipo Suction (regular)	
_____ Lipo Suction (Tumescent)	
_____ Mini Facelift	

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4. Does a physician meet with each patient prior to the scheduled procedure? ☐ Yes ☐ No
   *If no, explain: _____

5. How many non-medical employees do you employ?
   ☐ Aestheticians: _____ ☐ Massage Therapists: _____ ☐ Nutritionist: _____
   ☐ Cosmetologists: _____ ☐ Other (specify): _____

6. Do you manufacture, sell, handle, distribute or dispose of goods or products ? ☐ Yes ☐ No ☐ n/a
   a. What kind of products? _____
   b. Total Annual Sales? _____
   c. Do these products require prescription? ☐ Yes ☐ No ☐ n/a
   d. Do you label these products in your own name? ☐ Yes ☐ No ☐ n/a

7. Do you:
   a. Administer anesthesia (other than topical) ☐ Yes ☐ No ☐ n/a
   b. Dispense controlled narcotics? ☐ Yes ☐ No ☐ n/a
   c. Dispense weight loss drugs? ☐ Yes ☐ No ☐ n/a
   d. Train employees to properly operate medical equipment? ☐ Yes ☐ No ☐ n/a
   e. Have a formal equipment maintenance program in place ? ☐ Yes ☐ No ☐ n/a
   f. Accept walk-ins? ☐ Yes ☐ No ☐ n/a
   g. Provide after-hours or in-home care? ☐ Yes ☐ No ☐ n/a
   h. Have an exercise facility on site? ☐ Yes ☐ No ☐ n/a
      *If yes, is it open to the public? ☐ Yes ☐ No ☐ n/a
   i. Perform any surgical procedures? ☐ Yes ☐ No ☐ n/a
      *If yes, explain: _____

This application does not bind YOU or US to complete the insurance, but it is agreed that the information contained herein shall be the basis of the contract should a policy be issued.

APPLICANT'S NAME AND TITLE: _____

APPLICANT'S SIGNATURE: _____ DATE: _____
(Must be signed by an active owner, partner or executive officer.)

PRODUCER'S SIGNATURE: _____ DATE: _____