

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 Reduction	<input type="checkbox"/> Erectile Dysfunction – P Shots

<input type="checkbox"/> PRP with Body Injections (i.e. Dermal Filler) ** Injectable supplement application required	<input type="checkbox"/> Teaching / certifying others in PRP ** Teaching application required
<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 = REGISTERD PRACTICAL NURSE D = DOCTOR O = OTHER (PLEASE LIST)

Claims History:

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

5. 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.

Full Claims Information: _____

