

**PLASMA PEN SUPPLEMENTAL APPLICATION**

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

<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 PLASMA 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)

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.