Breckenridge INSURANCE

3550 George Busbee Pkwy NW, Suite 300 • Kennesaw, GA 30144

Cryotherapy Program – IV Therapy Supplemental

NAMED INSURED_____FEIN_____

1) Who performs the IV Therapies:

Name:	Yrs Exp	Licensing (i.e. EMT, LVN, etc)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do these people all carry their own professional liability? _____
Are you anticipating providing their professional liability on this policy? _____
Do you perform background checks on these people, including licensing checks and disciplinary actions against their licensing? _____

2) Types of IVs (please check all that apply):
   a. ☐ Hydration/Saline
   b. Vitamins/OTC supplements – Please list

      _____
      _____
      _____

   c. Pain Management

      _____
      _____
      _____

   d. Do you provide any weight loss injections or other weight loss treatments including but not limited to Semaglutide (aka Ozempic or other similar brands); Fen-Phen, HCG or any other IV or Injection therapy designed for weight loss? ☐ Yes ☐ No If yes, please provide details:

      _____

   e. Other: _____

   f. Do any medications require a doctor's prescription per the FDA? If so, please provide details on protocols and who is prescribing. ☐ Yes ☐ No

      _____
      _____
      _____

3) What is the youngest age that your center will provide IV services to? _____
4) Does your center have a medical director?_____Do they need to be covered on this policy? _____
5) Do you obtain a signed informed consent warning of any/all potential allergies and adverse reactions from these services?_____(Please provide copy)
6) Please describe your sterilization procedures for all equipment: _____

   _____
   _____

This application will become part of the policy as a warranty of exposures.

Signed: _____

Title: _____

Date: _____