

Gloucester County Department of Health

**APPLICATION FOR APPROVAL TO OPERATE A BODY ART ESTABLISHMENT**  
(AUTHORITY: N.J.A.C. 8:27-1 et seq.)

<b>Type of Establishment</b>		<b>Type of Establishment</b>	
<input type="checkbox"/> Tattoo <input type="checkbox"/> Permanent Cosmetics <input type="checkbox"/> Body Piercing <input type="checkbox"/> Ear Piercing		<input type="checkbox"/> Renewal \$250 <input type="checkbox"/> Renovation \$250 <input type="checkbox"/> New Facility \$400 <input type="checkbox"/> Temp Event \$1,000 <input type="checkbox"/> New Facility (ear piercing) \$250	
<b>ESTABLISHMENT IDENTIFICATION</b>			
Name and Mailing Address of Owner or Corporation		Name and Address of Establishment	
Telephone Number at Mailing Address (      )		Telephone Number at Establishment Location (      )	
Name of Operator	Fax Number (      )	E-Mail Address	
If any of the above information has changed, check the appropriate box(es) and make the correction(s) below:			
<input type="checkbox"/> Owner/Corporation Name _____ <input type="checkbox"/> Establishment Location _____ <input type="checkbox"/> Mailing Address _____  <input type="checkbox"/> Tel. # at Mailing Address (      ) <input type="checkbox"/> E-Mail Address _____ <input type="checkbox"/> Establishment Name _____ <input type="checkbox"/> Tel. # at Location (      ) <input type="checkbox"/> FAX Number (      ) <input type="checkbox"/> Operator _____			
<b>ESTABLISHMENT INFORMATION</b>			
Names of Corporate Officers:		Names of Partners:	
Name of all practitioners: Practitioner: _____      Describe Body Art performed: _____ 1. _____      1. _____ 2. _____      2. _____ 3. _____      3. _____ 4. _____      4. _____ 5. _____      5. _____ 6. _____      6. _____		Please submit the following information: <input type="checkbox"/> Municipal zoning approval <input type="checkbox"/> Approval from local construction official <input type="checkbox"/> Labeled floor plan of layout (LxW of procedure area) <input type="checkbox"/> <b>Copy of malpractice insurance for each practitioner</b> <input type="checkbox"/> <b>Regulated Medical Waste Generator number/verification</b> <input type="checkbox"/> Photograph of autoclave (make, model, ser.# on back) <input type="checkbox"/> Manufacturer's instructions for the autoclave <input type="checkbox"/> Negative biological of autoclave <input type="checkbox"/> Inventory and manufacturer info of equipment, jewelry, inks <input type="checkbox"/> Copy of client application and medical history <input type="checkbox"/> Copy of informed consent for each procedure <input type="checkbox"/> Copy of after care instructions for each procedure <input type="checkbox"/> Policies for latex allergies  <b>Renewal applications need only submit changes to the above information and highlighted items</b>	
Water Supply	Waste Disposal	Hours of Operation: _____ Days of Operation: _____	
<input type="checkbox"/> Municipal <input type="checkbox"/> Well	<input type="checkbox"/> Sanitary Sewer <input type="checkbox"/> Septic System		
<b>CERTIFICATION BY APPLICANT</b>			
<p>I have received and read Chapter 8 of The New Jersey State Sanitary Code and I certify that this Body Art Establishment meets these standards. I understand that obtaining a permit by means of fraud, misrepresentation or concealment shall result in closure of the Body Art Establishment. I certify the statements made in this application are true, complete and correct to the best of my knowledge and belief.</p>			
Name of Applicant (Print)		Title of Applicant	
Signature of Applicant		Date	