Department of Health

Permanent

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

Type of Establishment	**FOR DEPARTMENT USE ONLY**
☐ Tattoo ☐ Permanent Cosmetics ☐ Body Piercing ☐ Ear Piercing	Amount Received: $_____ Date: ___/___/____ ☐ Check ☐ Money Order Check No.:

ESTABLISHMENT IDENTIFICATION

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:

☐Owner/Corporation Name _____
☐Mailing Address _____
_____
☐Tel. # at Mailing Address ( ) _____
☐Establishment Name _____
☐FAX Number ( ) _____

☐Establishment Location _____
_____
☐E-Mail Address _____
☐Tel. # at Location ( ) _____
☐Operator _____

ESTABLISHMENT INFORMATION

Names of Corporate Officers:	Names of Partners:
_____ _____ _____	_____ _____ _____

Name of all practitioners: Practitioner:	Describe Body Art performed: Specialty:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____

Please Submit Qualifications for the following:

☐ Operator
☐ Practitioner
☐ Apprentice

Renewal applications need only to submit the Names and Qualifications of new staff.

Please submit the following information:

☐ Municipal zoning approval
☐ Approval from local construction official
☐ Inventory of processing equipment, jewelry, inks
☐ Description of all services provided
☐ Photograph, negative biological of autoclave
☐ Manufacturer's instructions for the autoclave
☐ Copy of malpractice insurance for each practitioner
☐ Copy of informed consent for each procedure
☐ Copy of after care instructions for each procedure
☐ Copy of client application
☐ Policies for HBV vaccine series
☐ Policies for latex allergies
☐ Written agreement with physician
(Body piercing and permanent cosmetics only)

Renewal applications need only submit changes to the above information

Water Supply	Waste Disposal	Hours of Operation: _____ Days of Operation: _____
☐ Municipal ☐ Well	☐ Sanitary Sewer ☐ Septic System	

CERTIFICATION BY APPLICANT

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.

Name of Applicant (Print)	Title of Applicant
Signature of Applicant	Date