

Monmouth County Health Department

50 E. Main St
Freehold, NJ 07728
(732) 431-7456
health@co.monmouth.nj.us

BODY ART ESTABLISHMENT APPLICATION

Owner's Name _____ Telephone # _____

Home Address _____
Street Address

_____ Municipality State Zip Code

Email _____

Business Name _____ Telephone # _____

Address _____ Fax #/e-mail _____
Street Address

_____ Municipality State Zip Code

Hours of operation _____

Applicant (check one) _____ Individual _____ Partnership _____ Firm or Corporation

List all partners/officers and addresses of corporation/firm:

Check all of the following services you will be providing:

- Body Piercing
- Ear Piercing (trailing edge of ear)
- Permanent Cosmetics
- Tattooing
- Other (specify) _____

Solid waste removal company _____

Containers _____ Dumpster _____

Name of operator _____

***The following documentation for the operator must be submitted with this application:

- Verification of 12 months' previous experience in operating a body piercing/tattooing facility

Name(s) of practitioner(s) _____

Check services provided:

- Body piercing (1000 hrs of training)
- Tattooing (2000 hrs. of training)
- Permanent cosmetics (40 hrs. of training)
- Ear piercing (Certificate of training)

Name(s) of practitioner(s) _____

Check services provided:

- Body piercing (1000 hrs. of training)
- Tattooing (2000 hrs. of training)
- Permanent cosmetics (40 hrs. of training)
- Ear piercing (Certificate of training)

Name(s) of practitioner(s) _____

Check services provided:

- Body piercing (1000 hrs. of training)
- Tattooing (2000 hrs. of training)
- Permanent cosmetics (40 hrs. of training)
- Ear piercing (Certificate of training)

Name(s) of practitioner(s) _____

Check services provided:

- Body piercing (1000 hrs. of training)
- Tattooing (2000 hrs. of training)
- Permanent cosmetics (40 hrs. of training)
- Ear piercing (Certificate of training)

*** The following documentation must be provided for each practitioner with this application:

Provide Evidence of completion of a blood borne pathogen course (body piercing and tattooing only)
Copy of certification from American Academy of Micropigmentation (permanent cosmetics only)
Areola restoration requires a copy of 8 hour training program (permanent cosmetics only)
Documentation of completion of a training program (ear piercing only)
Proof of professional malpractice liability insurance for each practitioner

Other (specify) _____

Name of licensed physician used for consultative purposes _____
(body piercing and permanent cosmetics only)

Medical waste company name: _____

Medical waste generators permit # _____

***Submit a copy of the Medical Waste Permit

List any employees who have received the Hepatitis B vaccination series _____

Autoclave: Submit for review - a photograph of steam autoclave with make, model # and serial # printed on the back

A copy of the manufacturer's instructions for operation of the autoclave

Name of biological monitoring laboratory _____ Tele # _____

Will you be reprocessing reusable equipment? Yes No

Will you be needle building? Yes No

The following paperwork must be submitted with this application:

- 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)
- Documentation of qualifications for all personnel
- Plan review application fee (New Facility \$ 150.00 Facility Revision \$ 50.00)

CERTIFICATION BY APPLICANT

I have received and read Chapter 27 of the New Jersey Administrative Code, and I certify that this Body Art Establishment meets these standards. I understand that obtaining a license 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

FOR HEALTH DEPARTMENT USE ONLY

Application Submitted _____ Paid: _____ License # _____

Date Approved _____ Signed By _____