Burlington County Health Department

15 Pioneer Boulevard PO Box 6000
Mount Holly NJ 08060
Tele: 609-265-5515 Fax: 609-265-5541

Permanent Location
(brick and mortar)

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	Date Received : ___/___/____Fee Paid_____ Inspector:_____ ☐ Approved ☐ Disapproved Date Completed_____

ESTABLISHMENT IDENTIFICATION

Name and Mailing Address of Owner or Corporation	Name and Address of Establishment Municipality
Telephone Number at Mailing Address ( )	Telephone Number at Establishment Location ( )
Fax Number ( ) E-Mail Address	Name of Operator

FACILITY INFORMATION:

Status:
- ☐ New **FEE- ONE HUNDRED DOLLARS($100.00)**
- ☐ Alteration **FEE-SEVENTY FIVE DOLLARS($ 75.00)**
- ☐ Other _____

(FEES PAYABLE TO COUNTY OF BURLINGTON)

Name of Laboratory:_____

Trash Removal System:
- ☐ Compactor
- ☐ Dumpster
- ☐ Other_____

Hazardous Material Hauler:_____

Address:_____

ESTABLISHMENT INFORMATION

Names of Corporate Officers:

_____

_____

Names of Partners:

_____

_____

Name of all Practitioners: Describe Body Art Performed:

Practitioner:	Specialty:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please Submit Qualifications/Training for the following:
- _ Operator
- _ Practitioner
- _ Apprentice

.Well Water Test Results: __ Bacteria __ Nitrates (if applicable)

Please Submit the Following Information:
- _ Municipal Zoning/Planning Approval in writing
- _ A clearly labeled floor plan showing layout of facility
- _ Inventory of Processing Equipment, Jewelry, Inks
- _ Description of all Services Provided
- _ Photograph, Negative Biological of Autoclave
- _ Manufacturer's Instructions for the Autoclave with a picture having make, model, and serial number on back
- _ 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
- _ Name/Address of manufacturers of equipment, ink, etc.
- _ Written Agreement with Physician (Body Piercing & Permanent Cosmetics Only)
- _ Training Documentation
- _ Photograghs of work

Potable Water Supply	Sewage Disposal System	
_ Municipal _ Well	_ Sanitary Sewer _ Septic System	Hours of Operation: _____ Days of Operation: _____

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