

**Town of Kearny  
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>FOR DEPARTMENT USE ONLY</b>	
<input type="checkbox"/> Tattoo(\$250) <input type="checkbox"/> Permanent Cosmetics(\$250) <input type="checkbox"/> Body Piercing(\$100) <input type="checkbox"/> Ear Piercing(\$50)		Inspector's Initials: _____ Approved/Denied: _____ Fee: _____ Cash/Check #: _____ License #: _____ Issue Date: _____ Expiration Date: _____	
<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"/> E-Mail Address _____	
<input type="checkbox"/> Tel. # at Mailing Address (      )		<input type="checkbox"/> Tel. # at Location (      )	
<input type="checkbox"/> Establishment Name _____		<input type="checkbox"/> Operator _____	
<input type="checkbox"/> FAX Number (      )			
<b>ESTABLISHMENT INFORMATION</b>			
Names of Corporate Officers:		Names of Partners:	
_____		_____	
_____		_____	
_____		_____	
Name of all practitioners:                      Describe Body Art performed: Practitioner:                                      Specialty:		Please submit the following information:	
1. _____ 1. _____		<input type="checkbox"/> Municipal zoning approval	
2. _____ 2. _____		<input type="checkbox"/> Approval from local construction official	
3. _____ 3. _____		<input type="checkbox"/> Inventory of processing equipment, jewelry, inks	
4. _____ 4. _____		<input type="checkbox"/> Description of all services provided	
5. _____ 5. _____		<input type="checkbox"/> Photograph, negative biological of autoclave	
6. _____ 6. _____		<input type="checkbox"/> Manufacturer's instructions for the autoclave	
		<input type="checkbox"/> Copy of malpractice insurance for each practitioner	
		<input type="checkbox"/> Copy of informed consent for each procedure	
		<input type="checkbox"/> Copy of after care instructions for each procedure	
		<input type="checkbox"/> Copy of client application	
		<input type="checkbox"/> Policies for HBV vaccine series	
		<input type="checkbox"/> Policies for latex allergies	
		<input type="checkbox"/> Written agreement with physician	
		(Body piercing and permanent cosmetics only)	
		RENEWAL APPLICATIONS NEED TO ONLY SUBMIT THE ABOVE INFORMATION IF ANY CHANGES OCCURRED. ALL BODY ART ESTABLISHMENT LICENSES ANNUALLY EXPIRE ON FEBRUARY 1 <sup>st</sup> .	
Please Submit Qualifications for the following:			
<input type="checkbox"/> Operator			
<input type="checkbox"/> Practitioner			
<input type="checkbox"/> Apprentice			
<b>Renewal applications need only to submit the Names and Qualifications of new staff.</b>			
Water Supply		Waste Disposal	
<input type="checkbox"/> Municipal <input type="checkbox"/> Well		<input type="checkbox"/> Sanitary Sewer <input type="checkbox"/> Septic System	
		Hours of Operation: _____	
		Days of Operation: _____	
<b>CERTIFICATION BY APPLICANT</b>			
<i>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.</i>			
Name of Applicant (Print)		Title of Applicant	
Signature of Applicant			Date