

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

Type of Establishment <input type="checkbox"/> Tattoo <input type="checkbox"/> Other: _____ <input type="checkbox"/> Body Piercing	FOR DEPARTMENT USE ONLY	
	Amount Received: \$ _____ Date: ___/___/___ <input type="checkbox"/> Check <input type="checkbox"/> Money Order   Check No.: _____	
ESTABLISHMENT IDENTIFICATION		
Name and Mailing Address of Owner or Corporation	Address of the Event	
	Name of Operator or Convention Manager (      )	
Telephone Number at Mailing Address (      )	Telephone Number at Establishment Location (      )	
Fax Number at Mailing Address (      )	Fax Number at Establishment Location (      )	
Email Address (      )	Email Address (      )	
Names of Corporate Officers/Partners:  _____ _____ _____	Address of Corporate Officers/Partners:  _____ _____ _____	
ESTABLISHMENT INFORMATION		
Please submit the following information: <input type="checkbox"/> Photograph, negative biological of autoclave <input type="checkbox"/> Manufacturer's instructions of autoclave <input type="checkbox"/> Location of processing area <input type="checkbox"/> Location of sink <input type="checkbox"/> Manufacturer's instructions ultra-sonic equipment <input type="checkbox"/> Type of containers used to transport soiled equipment <input type="checkbox"/> Policies and procedures for sterilization <input type="checkbox"/> Policies for control of back to original practitioner <input type="checkbox"/> Record keeping <input type="checkbox"/> Method of transport of sterile supplies back to practitioner <input type="checkbox"/> Samples of packaging material and chemical integrators	Please submit the following information: <input type="checkbox"/> Purpose for which the permit is requested <input type="checkbox"/> Floor plan drawn to scale <input type="checkbox"/> Description of all services provided <input type="checkbox"/> Name and addresses of all practitioners <input type="checkbox"/> Medical waste generator ID number <input type="checkbox"/> Policies for collection of regulated medical waste <input type="checkbox"/> Policy regarding minors and system to monitor <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 hand washing <input type="checkbox"/> Samples of waterless hand washing agent <input type="checkbox"/> Policies for reporting infections and injuries <input type="checkbox"/> Written instructions provided to each artist before event Please instruct all practitioners to bring a current copy of a Negative Biological for the autoclave used to process equipment prior to the event.	
Outline of any training programs offered at the event:		
Alcohol on premises? <input type="checkbox"/> Yes <input type="checkbox"/> No	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	