



WESTPORT WESTON HEALTH DISTRICT

180 Bayberry Lane, Westport, CT 06880-2855

Telephone: (203) 227-9571

FEE: \$ _____.

APPLICATION TO OPERATE A COSMETOLOGY SHOP

Fee is Non-Refundable

Business Name: _____ **Phone:**(____) _____

Email Address: _____ **Fax:**(____) _____

Business Address: _____ **Town:** _____

Mailing Address: _____ **Town:** _____ **ZIP:** _____

Services:

- Barber Shop Cosmetology Shop Massage
 Hairdressing Shop Permanent Make-up/Tattoo Botox

Type of Ownership: (Mark one) Individual Partnership Corporation Other

If Individual Ownership:

Name: _____ **Phone:** (____) _____ **Cell:** (____) _____
Home Address: _____ **Town:** _____ **ZIP:** _____

If Partnership, List all Partners:

Name: _____ **Phone:** (____) _____ **Cell:** (____) _____
Home Address: _____ **Town:** _____ **ZIP:** _____

Name: _____ **Phone:** (____) _____ **Cell:** (____) _____
Home Address: _____ **Town:** _____ **ZIP:** _____

Name: _____ **Phone:** (____) _____ **Cell:** (____) _____
Home Address: _____ **Town:** _____ **ZIP:** _____

If Corporation, list Corporation Name and all Officers:

Corporation Name: _____ **Phone:** (____) _____ **Cell:** (____) _____
Address: _____ **Town:** _____ **ZIP:** _____

President: _____ **Phone:** (____) _____ **Cell:** (____) _____
Home Address: _____ **Town:** _____ **ZIP:** _____

Vice President: _____ **Phone:** (____) _____
Home Address: _____ **Town:** _____ **ZIP:** _____

Secretary: _____ **Phone:** (____) _____
Home Address: _____ **Town:** _____ **ZIP:** _____

Treasurer: _____ **Phone:** (____) _____
Home Address: _____ **Town:** _____ **ZIP:** _____

I attest that the information supplied here is accurate and correct. I understand that this permit may not be issued or, after issuance, may be suspended, revoked or not renewed for noncompliance with the *Westport Weston Sanitary Code* and/or the *Connecticut State Public Health Code*.

Signature and Title

TYPE or Print Name

Date

For Office Use Only

Date Application Approved:	Date Permit Issued:	Date Permit Mailed/Delivered:
By:	By:	By:

Number of Pedicure Chairs: _____ Number of Manicure Stations: _____ Number of Barbering Chairs: _____ Number of Treatment Rooms: _____ TOTAL # OF CHAIRS, STATIONS & ROOMS: _____
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Number of Licensed Individuals, employed: _____

You must include copies of all CT licenses of service providers as required by State of CT General Statutes and Division of Health Systems Regulation. * See following attachment for new CT license requirements*

Are you renting chairs or leasing space? _____ If so, please include a copy of your written agreement

Check all procedures performed on premises:

- Cutting, trimming, shaving, or singeing the hair
- Shampooing, dressing, styling, curling, waving, or weaving the hair
- Dyeing, bleaching, or coloring the hair
- Facials, cleansing, application of cosmetic preparations, tonics, antiseptics, powders, oils, clays, creams, or lotions to the head, scalp, face, or neck
- Microdermabrasion
- Eyebrow arching, threading
- Hair removal by waxing
- Eyelash extensions, eyelash lifts, eyelash perms, eyelash color tints
- Manicures
- Pedicures
- Massaging or manipulating the head, scalp, face, neck, arms, hands, body, legs, or feet; includes all types of massage therapy and reflexology

If you perform the following services, please see attachment with additional requirements.

- Tattooing, permanent makeup, microblading
- Botox, dermal fillers
- Hair removal by electrolysis, laser treatments
- Body Piercings

Water Supply: Public Private

Sewage Disposal: City Sewer Septic system

List all chemicals and sterilizing devices used for sanitizing/disinfecting purposes: _____
