



**MONMOUTH COUNTY REGIONAL HEALTH COMMISSION #1**  
 1540 West Park Avenue, Suite 1, Ocean, New Jersey 07712  
 Telephone (732) 493-9520 Facsimile (732) 493-9521  
[www.mcrhc.org](http://www.mcrhc.org)

<b>Permanent</b> Fee Plan Review (New): \$300 Annual Permit: \$160 Ordinance No. 15-06
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**APPLICATION FOR APPROVAL TO OPERATE A BODY ART ESTABLISHMENT**  
 (AUTHORITY: N.J.A.C. 8:27-1 et seq.)

<b>Type of Establishment</b> <input type="checkbox"/> Tattoo <input type="checkbox"/> Body Piercing <input type="checkbox"/> Permanent Cosmetics <input type="checkbox"/> Ear Piercing		<b>FOR DEPARTMENT USE ONLY</b> Amount Received: \$ _____ Date: ___/___/___ <input type="checkbox"/> Check <input type="checkbox"/> Money Order Check No.: _____	
<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: Practitioner: Describe Body Art performed: Specialty: 1. _____ 1. _____ 2. _____ 2. _____ 3. _____ 3. _____ 4. _____ 4. _____ 5. _____ 5. _____ 6. _____ 6. _____		Please submit the following information: <input type="checkbox"/> Municipal zoning approval <input type="checkbox"/> Approval from local construction official <input type="checkbox"/> Inventory of processing equipment, jewelry, inks <input type="checkbox"/> Description of all services provided <input type="checkbox"/> Photograph, negative biological of autoclave <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) <b>Renewal applications need only submit changes to the above information.</b>	
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 <input type="checkbox"/> Municipal <input type="checkbox"/> Well	Waste Disposal <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	