



TOWN OF NORTHBRIDGE  
**BOARD OF HEALTH**

7 Main Street  
Whitinsville, MA 01588  
Phone# (508) 234-3272 Fax# (508) 234-0821

**APPLICATION FOR PERMIT TO OPERATE A BODY ART ESTABLISHMENT**

Date: \_\_\_\_\_

Permit Fee: \$200.00

**Establishment Information**

Name of Body Art Establishment: \_\_\_\_\_

Address of Establishment: \_\_\_\_\_

Phone Number of Establishment: \_\_\_\_\_

Hours of Operation: \_\_\_\_\_

**Operator Information**

Name and Address of Operator of Body Art Establishment: \_\_\_\_\_

\_\_\_\_\_

Operator's Phone Number: \_\_\_\_\_

**Body Art Practioners**

Please list names of all Body Artists working at this establishment

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**Autoclave Information**

Model Number: \_\_\_\_\_

Model Year: \_\_\_\_\_

Serial Number: \_\_\_\_\_

Is the autoclave capable of operating for a minimum of thirty minutes at 20 pounds of pressure at a temperature of 270 degrees Fahrenheit?  YES  NO

**Spore Testing**

Name and Address of Independent Laboratory conducting monthly spore testing on autoclave: \_\_\_\_\_  
\_\_\_\_\_

Phone Number of Laboratory: \_\_\_\_\_

**Hazardous Waste Removal Company**

Name and Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number of Waste Company: \_\_\_\_\_

**Name of EPA approved Disinfectant:** \_\_\_\_\_

**Required Documents to Accompany this Application:**

1. Copy of Consent Forms including aftercare instructions to be used
2. Floor plan to scale noting location and size of each body art station, hand sink, and lavatory
3. Exposure Report Plan
4. Signed Revenue Enforcement And Protection Attestation form
5. Copy of Driver's License and Social Security Number

I verify that I have read the Northbridge Board of Health rules and regulations governing Body Art and agree to abide by them.

\_\_\_\_\_  
Print Name of Applicant

\_\_\_\_\_  
*Signature of Applicant*

\_\_\_\_\_  
*Date*

In addition, it is my understanding that the issuance of this permit is subject to the results of a criminal record check on me by the Northbridge Police Department, and thereto I have furnished to the Board of Health a copy of my Driver's license and Social Security Number.

\_\_\_\_\_  
*Signature of Applicant*

\_\_\_\_\_  
*Date*

**MASSACHUSETTS DEPARTMENT OF REVENUE**

**REVENUE ENFORCEMENT AND PROTECTION (REAP) ATTESTATION**

I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under the law.

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\* Signature of Individual or Corporate Name (Mandatory)

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By: Corporate Officer (Mandatory, if applicable)

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\*\*Social Security Number (Voluntary) or Federal Identification Number

\* This license/permit will not be issued unless this certification clause is signed by the applicant.

\*\* Your Social Security number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Massachusetts General Laws Chapter 62C, Section 49A.