TOWN OF NORTHBRIDGE
BOARD OF HEALTH
Aldrich School Town Hall Annex - 14 Hill 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.

_____

* Signature of Individual or Corporate Name (Mandatory)

_____

By: Corporate Officer (Mandatory, if applicable)

_____

**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.

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
1 Congress Street, Suite 100
Boston, MA 02114-2017
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information **Please Print Legibly**

Business/Organization Name:_____

Address:_____

City/State/Zip:_____ Phone #:_____

Are you an employer? Check the appropriate box:

1. ☐ I am a employer with _____ employees (full and/ or part-time).*
2. ☐ I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
3. ☐ We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**
4. ☐ We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

Business Type (required):

5. ☐ Retail
6. ☐ Restaurant/Bar/Eating Establishment
7. ☐ Office and/or Sales (incl. real estate, auto, etc.)
8. ☐ Non-profit
9. ☐ Entertainment
10. ☐ Manufacturing
11. ☐ Health Care
12. ☐ Other _____

*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.
**If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.

Insurance Company Name:_____

Insurer's Address:_____

City/State/Zip: _____

Policy # or Self-ins. Lic. #_____ Expiration Date:_____

Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).

Failure to secure coverage as required under Section 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to $1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to $250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.

Signature:_____ Date:_____

Phone #:_____

Official use only. Do not write in this area, to be completed by city or town official.

City or Town: _____ **Permit/License #**_____

Issuing Authority (circle one):
1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office
6. Other _____

Contact Person:_____ **Phone #:**_____