

Application for Registration of Body Art Practitioner

Purpose of Application

☐ First year registration

☐ Annual renewal

☐ Update information

Practitioner & Site of Operation Information (print legibly)

Practitioner Information	Full name of practitioner:			Date of birth		
	Personal ID/CA driver's Lic.#		Contact phone number		Additional contact phone number	
	Email address					
	Residential address		City		State Zip Code	
	Mailing/billing address		City		State Zip Code	
Site of Operation	Name of business					
	Type of business					
	Business physical address		City		State Zip Code	
	Business phone number			FAX number		
	Owner/manager name			Contact number		

Body Art Procedures to be Performed

☐ Tattooing ☐ Body piercing ☐ Other (describe) _____
☐ Permanent cosmetics ☐ Branding

Body Art Operation Period (Days & Hours)

☐ Ongoing operation ☐ Seasonal operation (give range of dates)
☐ Other (describe) _____

Check days and hours providing body art services:

Days	<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Friday	<input type="checkbox"/> Saturday	<input type="checkbox"/> Sunday
Hours							

Registration Requirements

Hepatitis B

- ☐ I have provided documentation demonstrating the completion of Hepatitis B vaccination including applicable boosters
☐ I have provided laboratory evidence of immunity to Hepatitis B
☐ I have provided documentation complying with current federal OSHA Hepatitis B vaccination declination requirements

OSHA Bloodborne Pathogen Training

- ☐ I have provided documentation of completion of OSHA Bloodborne Pathogen Training

18 or Older

- ☐ I have provided proof that I am 18 year of age or older.

Certification & Agreement

I hereby certify under penalty of perjury that the information supplied on this application is true and correct.

- I understand that the registration issued subsequent to this application shall become void and the fee forfeited upon falsification of any portion of this application.
- I am aware that, should a registration be granted, I will be responsible to know and observe all requirements that are currently enforced or may hereafter be put in force pertaining to the above named operation.
- I recognize that if my operation fails to meet applicable sanitation laws, regulations, and/or ordinances Imperial County Environmental Health may suspend or revoke registration and require closure of the operation.
- I understand that the issuance of registration certification by Imperial County Environmental Health does not imply any allowance to operate without meeting the requirements of any other department or agency having jurisdiction.
- I hereby consent to all inspections pertaining to the issuance of the registration and the operation described in this application.
- I understand that Imperial County Environmental Health must be notified of all proposed changes in operation at least 30 days prior to making the changes or starting the work.

Signature of applicant _____

Date _____

Printed name _____

Office Use Only

Facility ID# _____

Program # _____

Approved Date _____

Approved by _____

Comments

Imperial County Public Health Department, Environmental Health Division
 1221 W. State St., Suite B, El Centro CA 92243
 Phone: (442) 265-1888 Fax: (442) 265-1903
www.icphd.org

Office Use Only

Facility ID# _____ Payment Amt. _____ Penalty Amt. _____ Date _____

Payment Type ☐ Cash ☐ Check # _____ ☐ Credit Card # _____ Rcvd. By _____