West Windsor Township

271 Clarksville Road, West Windsor, NJ 08550 * Tel. (609) 799-2400 * Fax (609) 799-2044

DEPARTMENT OF HUMAN SERVICES
Division of Health

Body Art Establishment Plan Review Application

Date of Application: _____

Name of Establishment: _____

Location of Establishment:_____

_____

Establishment phone number: _____

Name of owner(s): _____
(If the applicant is a partnership, the names and addresses of the partners shall be provided. If the applicant is a corporation, the names and addresses of all corporate officers shall be listed. Attach an additional sheet if necessary.)

Mailing Address: _____

Owner phone: _____

Owner Email Address: _____

Owner emergency contact number: _____

Hours of operation: _____

Consulting Physician (If applicable): _____Phone: _____

Physician Address: _____

Plan Review Fee (cash or check): $500 Base + $125 for each additional procedure proposed

Procedures to be performed onsite: (Check all that apply)

☐ Body Piercing ☐ Tattooing ☐ Permanent Cosmetic ☐ Ear Piercing

Other, please list: _____

Category (Check one):

☐ New Establishment
☐ Renovation to Existing Establishment
☐ Temporary Establishment

The following information must be attached to this application.

- ☐ A floor plan of the facility. (This plan shall indicate the layout of the reception area, the procedure areas, the cleaning and sterilization area, the storage area and the toilet facilities.)
- ☐ A photo of the steam autoclave with the make model and serial number printed on the reverse side. (If Applicable) & a copy of the manufacturer's specifications for the operation of the autoclave. (If Applicable)
- ☐ A negative biological indicator test result. (If Applicable)
- ☐ A copy of informed consent for each procedure and written care instructions.
- ☐ A copy of the written agreement with a consulting physician. (Recommended)
- ☐ Names and addresses of all manufacturers of processing equipment, instruments, jewelry, and inks used for any body art procedures.
- ☐ A complete description of all services to be provided, hours of operation, names of each practitioner and their exact duties (job description). A copy of the professional certification and/or training for each practitioner as per NJAC 8:26.
- ☐ A statement of approval from the Township Zoning Official.

Medical Waste Disposal provider: _____Phone: _____

Address: _____

The undersigned certifies that the information presented on this application is complete and accurate. The undersigned further agrees to operate this establishment in compliance with The New Jersey State Sanitary Code, Chapter VIII, Body Art Procedures, NJAC 8:27-1 et seq., and all applicable federal, state and local regulations and requirements. I have read and fully understand the attached *N.J.A.C. 8:27-2.6 Prohibitions* and agree to comply with such.

_____

Signature of owner(s) Date

For Office Use Only:

Board of Health Action:	Approved	Denied
License #	**Fee payment:**	