



**LIST ANY PREVIOUS, CURRENT, OR SIMILAR APPROVALS HELD BY THE OPERATOR FOR TATTOOING AND/OR PIERCING SERVICES (ATTACH ADDITIONAL PAGES IF NECESSARY)**

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DATES: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

BUSINESS NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

LICENSING AGENCY: \_\_\_\_\_

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DATES: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

BUSINESS NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

LICENSING AGENCY: \_\_\_\_\_

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DATES: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

BUSINESS NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

LICENSING AGENCY: \_\_\_\_\_

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**LIST ALL PERSONS PERFORMING TATTOOING OR BODY PIERCING SERVICES ON THE PREMISES, INCLUDING APPRENTICES:**

NAME: \_\_\_\_\_ DBHMC REG #: \_\_\_\_\_

NAME: \_\_\_\_\_ DBHMC REG #: \_\_\_\_\_

NAME: \_\_\_\_\_ DBHMC REG #: \_\_\_\_\_

NAME: \_\_\_\_\_ DBHMC REG #: \_\_\_\_\_

NAME: \_\_\_\_\_ DBHMC REG #: \_\_\_\_\_

NAME: \_\_\_\_\_ DBHMC REG #: \_\_\_\_\_

NAME: \_\_\_\_\_ DBHMC REG #: \_\_\_\_\_

NAME: \_\_\_\_\_ DBHMC REG #: \_\_\_\_\_

NAME: \_\_\_\_\_ DBHMC REG #: \_\_\_\_\_

NAME: \_\_\_\_\_ DBHMC REG #: \_\_\_\_\_

NAME: \_\_\_\_\_ DBHMC REG #: \_\_\_\_\_

**PLANS & SPECIFICATIONS:**

TOTAL AREA TO BE USED FOR THE BUSINESS: \_\_\_\_\_

LISTING OF ALL EQUIPMENT TO BE USED: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

FLOOR PLAN SHOWING GENERAL LAYOUT OF FIXTURES, EQUIPMENT, ENTRANCES AND EXITS, INDIVIDUAL WORK AREAS, LOCATION AND TYPES OF PLUMBING FIXTURES, AND LIGHTING, ETC: (TO SCALE).

**PLEASE MAKE SURE THE FOLLOWING ARE ATTACHED:**

(Initial Application Only)

- INFECTION CONTROL PLAN
- WRITTEN APPROVAL FROM ZONING DEPARTMENT HAVING JURISDICTION
- WRITTEN APPROVAL FROM BUILDING DEPARTMENT HAVING JURISDICTION

I/We as operators of the aforementioned business do attest to my/our intentions to comply with all requirements established by Sections 3730.01 to 3730.11 of the Ohio Revised Code and the rules of Chapter 3701-09 of the Administrative Code. I/We understand that any changes to the above information will require the submission of an amended application.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**HEALTH DEPARTMENT TO COMPELTE BELOW:**

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Permit Fee: \_\_\_\_\_

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

Check #: \_\_\_\_\_

Application approved for permit:

By: \_\_\_\_\_

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

Permit #: \_\_\_\_\_