ROCKLAND COUNTY HEALTH DEPARTMENT
CENTER FOR ROCKLAND CODES INVESTIGATIONS

2022 APPLICATION FOR PERMIT TO OPERATE A BODY ART ESTABLISHMENT IN ROCKLAND COUNTY

PURSUANT TO THE RC SANITARY CODE, ARTICLE XVI, COMPLETE ALL ITEMS THAT APPLY TO YOUR ESTABLISHMENT, SIGN ON THE BACK PAGE AND RETURN WITH A CHECK OR MONEY ORDER MADE PAYABLE TO THE **COMMISSIONER OF FINANCE** IN THE AMOUNT OF **$265.00** AT LEAST 30 DAYS PRIOR TO THE PERMIT EXPIRATION DATE TO:

ROCKLAND COUNTY HEALTH DEPARTMENT
CENTER FOR ROCKLAND CODES INVESTIGATIONS
ATTENTION: SUE AUGUSTONI
50 SANATORIUM ROAD, BUILDING D
POMONA, NEW YORK 10970

SECTION A: ESTABLISHMENT INFORMATION

(ALL APPLICANTS MUST COMPLETE THIS SECTION)

NAME: _____

ADDRESS: _____ TOWN: _____ STATE: _____ ZIP CODE: _____

BUSINESS TELEPHONE: _____

MUNICIPALITY: _____ ☐ TOWN ☐ VILLAGE

WATER SUPPLY:
☐ PUBLIC (MUNICIPAL)
☐ PRIVATE (ON-SITE)

SEWAGE SYSTEM:
☐ PUBLIC (MUNICIPAL)
☐ PRIVATE (ON-SITE)

DAYS OF OPERATION: ☐ SU ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ SA

HOURS OF OPERATION: _____ ☐ AM (OPEN) _____ ☐ PM (CLOSE)

LIST ALL BODY ART PRACTITIONERS AND EMPLOYEES: (add a separate sheet of paper if necessary)

LEGAL NAME	**Practitioner TRADE NAME**	**CAPACITY: tattoo, pierce, reception**	**CONTACT NUMBER**

AUTOCLAVE MANUFACTURER: _____ MODEL #: _____ MODEL YR: _____ SERIAL #: _____

NEW ESTABLISHMENT EXPECTED OPENING DATE: _____ MUST ATTACH FLOOR PLAN

SECTION B: OPERATOR/OWNER INFORMATION

(ALL APPLICANTS MUST COMPLETE THIS SECTION)

LEGAL OPERATOR OR OPERATING CORPORATION: _____
(IF CORPORATION OR PARTNERSHIP, SECTION C MUST BE COMPLETED)

PERSON IN CHARGE: _____

PERMANENT ADDRESS: _____

TOWN: _____ STATE: _____ ZIP: _____ TELEPHONE NUMBER: _____

EMPLOYER ID. NO.: _____ OR SOCIAL SECURITY NO.: _____

OWNER OF BUILDING: _____

PERMANENT ADDRESS: _____

TOWN: _____ STATE: _____ ZIP: _____ TELEPHONE NUMBER: _____

SECTION C: PARTNERS AND CORPORATE OFFICERS

LIST ALL PARTNERS AND CORPORATE OFFICERS IN THE OPERATION OF THE FACILITY. INCLUDE VICE PRESIDENT(S), SECRETARY, AND TREASURER. ATTACH ADDITIONAL SHEETS AS NECESSARY.

NAME	TITLE	ADDRESS	TELEPHONE NUMBER

SECTION D: WORKERS' COMPENSATION & DISABILITY INSURANCE

(ALL APPLICANTS MUST COMPLETE THIS SECTION)

THIS IS TO CERTIFY, UNDER THE PENALTIES OF PERJURY, THE OPERATION DESCRIBED IN THIS APPLICATION HAS WORKERS' COMPENSATION & DISABILITY BENEFITS COVERAGE REQUIRED BY LAW:

WORKERS' COMPENSATION CARRIER: _____
WORKERS' COMPENSATION POLICY #: _____ EXPIRATION DATE: _____

DISABILITY BENEFITS CARRIER: _____
DISABILITY BENEFITS POLICY #: _____ EXPIRATION DATE: _____

OR

☐ A REPRESENTATIVE OF THE WORKERS' COMPENSATION BOARD HAS ENDORSED FORM WC/DB-100 OR FORM WC/DB-101 STATING THAT SUCH COVERAGE IS NOT REQUIRED.

SECTION E: SIGNATURE

(ALL APPLICANTS MUST COMPLETE THIS SECTION)

I HEREBY ACKNOWLEDGE THAT I RECEIVED, READ AND UNDERSTAND THE REQUIREMENTS OF THE ROCKLAND COUNTY SANITARY CODE, ARTICLE XVI, BODY ART, INCLUDING THAT A PERMIT IS NOT TRANSFERABLE. FALSE STATEMENTS MADE ON THIS APPLICATION ARE PUNISHABLE UNDER PENAL LAW. FAILURE TO SIGN THIS FORM MAY DELAY ISSUANCE OF YOUR PERMIT TO OPERATE. OPERATION WITHOUT A VALID PERMIT IS A VIOLATION OF THE ROCKLAND COUNTY SANITARY CODE.

SIGNATURE OF INDIVIDUAL OPERATOR OR AUTHORIZED OFFICIAL: _____

PRINT NAME OF PERSON SIGNING APPLICATION: _____

TITLE: _____

DATE: _____

FOR OFFICIAL USE ONLY

PERMIT ISSUANCE RECOMMENDED? ☐ YES ☐ NO

PERMIT EFFECTIVE DATE: _____ PERMIT EXPIRATION DATE: _____

CONDITIONS OF APPROVAL? ☐ YES ☐ NO

SIGNATURE: _____ TITLE: _____ DATE: _____