



TOWN OF SEEKONK BOARD OF HEALTH

This permit will expire December 31, 20_____

Fee: **\$75.00**

APPLICATION FOR LICENSE TO OPERATE AN ESTABLISHMENT FOR A TATTOO

I, _____ hereby apply to the Board of Health of the Town of Seekonk, Massachusetts for a license to operate an establishment for Body Art and Body Piercing:

1. Name of Establishment: _____
2. Address of Establishment: _____
3. Phone number of Establishment: _____
4. Name and Address of owner: _____

The following information will need to be submitted with the application:

- | | |
|---|--------------------------|
| Occupancy Permit: | <input type="checkbox"/> |
| Procedure to verify credentials: | <input type="checkbox"/> |
| Procedure to maintain confidentiality: | <input type="checkbox"/> |
| Procedure to deal with exposures (must include CFR 1910.1030): | <input type="checkbox"/> |
| Procedure to address medical conditions that may harm and/or endanger the client: | <input type="checkbox"/> |
| Aftercare instructions: | <input type="checkbox"/> |
| Copy of consent form: | <input type="checkbox"/> |
| Copy of consent process: | <input type="checkbox"/> |
| Procedures regarding a client wanting to stop the procedure: | <input type="checkbox"/> |
| Letters of reference for practitioners: | <input type="checkbox"/> |
| Material Safety Data Sheets (MSDS): | <input type="checkbox"/> |
| Biological Waste Plan: | <input type="checkbox"/> |
| Procedure to maintain confidentiality, including exposure: | <input type="checkbox"/> |

I agree to abide by all the rules and regulations pertaining to this type of establishment as promulgated from time by the Board of Health of the Town of Seekonk.

Signature of applicant

Address and phone #of applicant

Pursuant to M.G.L. 62C, sec. 49A, I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and all state taxes required under law.

Social Security Number or
Federal Identification Number

Signature of Individual or Corporate Name

By: _____
Corporate Officer (if applicable)

Approved:

Chairman of the Board of Health

APPROVED AT THE BOARD OF HEALTH MEETING OF _____

PERMIT # _____