Department of Environmental Health
Hazardous Materials Compliance Division
County of Santa Clara
1555 Berger Drive, Suite 300
San Jose, CA 95112-***2716***
408-918-3400, fax 408-280-6479

CERTIFICATION STATEMENT
FOR FACILITY OWNER/OPERATOR/PRACTITIONER & LOWER LOBE EAR PIERCER

Please complete a separate Permit Application Packet for each Facility, Practitioner, or Lower Lobe Ear Piercer (LLEP)

Circle All That Apply to This Application:

Body Piercing	**Facility Owner/Manager**	**Lower Lobe Ear Piercing**	**Permanent Cosmetics**	**Tattooing**

If none of the above applies, then circle here: *NONE APPLIES*, fill out and sign this first page and mail it to the address indicated above

If applicable, you will be billed for an annual permit fee. A permit will not be issued until all fees have been paid. If you operate without a permit, you will be in violation of the Regulations.

NAME OF FACILITY, PRACTITIONER OR LLEP TO BE PERMITTED: ____________________________________

____

* NAME OF PERMITTED FACILITY OR APPROVED LOCATION: ______________________________

____

PRIMARY FACILITY ADDRESS: ____

ADDITIONAL SITE ADDRESSES: ____

FACILITY PHONE: ______________________FAX: ______________________

HOME ADDRESS: ____

HOME PHONE: ______________________CELL# ______________________

EMAIL: ____

* Practitioners and LLEP's May Operate Only At Permitted Facilities or Approved Locations

I hereby certify, under penalty of perjury, that to the best of my knowledge and belief, the statements made herein (and on any of the following pages) are complete, correct and true:

Signature: ______________________________ Date ______________

Print Name: ______________________________ Phone ______________

PERMIT APPLICATION – Body Art Facility, Practitioner or Lower Lobe Ear Piercer (LLEP)

Department of Environmental Health - Santa Clara County
1555 Berger Dr, Ste 300, San Jose CA 95112-2716
ph - 408-918-3400 fax – 408-280-6479

Name of Facility, Practitioner or LLEP to be Permitted ______________________________

* Name of Permitted Facility or Approved Location ______________________________

Primary Site Address ______________________________
Street #, Street Name, Type, Unit #, City St Zip

List Any Other Locations in Santa Clara County where Applicant is in Operation ______________________________

____

Billing Address ______________________________
Street #, Street Name, Type, Unit # City St Zip

Facility Telephone (_____) ______________________ Fax (_____) ______________________

Contact Name ______________________ Phone ______________________

The undersigned hereby applies for a Permit to Operate and **agrees to operate in accordance with all applicable state and local regulations, laws, ordinances, and codes**, and to such inspection procedures needed to ensure compliance. Payment of the required fee(s) and late penaltie(s), if any, to secure a valid permit, is required before commencing or continuing operations. Failure to do so may result in a misdemeanor citation, permit suspension/revocation proceedings, and/or closure. Notify the Department of Environmental Health of any change in the type of business activity, name, billing address, or ownership by calling the number above. PERMITS AND FEES ARE NOT TRANSFERABLE.

____

Signature of Facility Owner/Agent/Manager, Practitioner or LLEP Title Date

Print Name ______________________________

* Practitioners and LLEP's May Operate Only At Permitted Facilities or Approved Locations

- DO NOT WRITE BELOW THIS LINE BUT DO CONTINUE TO THE NEXT PAGE -

θ New Owner θ New Facility θ New Program θ Ownership Change θ Facility Name Change θ Billing Address Change

Switch to New Owner Record #: __________ Switch to Existing Owner Record #: __________ Change of Status: __________

Comments (explain change of status here} ______________________________

Application Approved By: __________ Emp # ______ Date: ______ Supervisor: __________

PERMIT APPLICATION (continued)

Name of Facility, Practitioner or LLEP to be Permitted: ____

Owner or Manager Responsible for the Body Art or LLEP operations at the Facility or Approved Location applicable to this Application - Name: ____________________________________Title ___________

Please list all Practitioners or LLEP's that practice at this Facility or Approved Location (attach another page if needed):

____

LLEP Applicant May Stop Filling Form Out Here – **The following applies to (a) Facility and/or (b) Practitioner**

(a) Facility

Will this business or service generate Sharps Waste (tattoo needles, piercing needles, needle tubes, bars, disposable razors or blades, syringes or needles)?

Yes _____ No _____ If so, sharps must be placed in a commercial sharps container and disposed of in an approved manner. List the name of the Sharps Mailback Service or Registered Hazardous Waste Hauler that will remove the Sharps Waste:

Name ____ Phone # ____________________________

Address ____ Collection frequency ___________

In the event of failure of the plan described above, (e.g., Sharps Waste hauler is unable to pick up the Sharps Waste at the designated time), what will be the alternative method to remove Sharps Waste? (example…'Will call another registered haz. waste hauler for pickup')

____

Please describe, in detail, how the facility will manage a sharps waste spill:
(e. g. gloves, mask, gown, disinfectant, forceps, tongs or tweezers, spill kit) ___________________

____

The facilities' "Exposure Control Plan" is located where, and are all of the employees trained in and aware of its location (See Regulations Section XI)? Explain: _________________________________

____

(a) Facility and (b) Practitioner

A Facility, Approved Location and Practitioner must utilize Client Information & Consent Forms and Aftercare Forms & Instructions. Please read Sections XVI A & I of the Body Art Regulations and Describe the use of these Forms and Instructions:

____

____

(b) Practitioner

- **Provide proof of Bloodborne Pathogens Training WITH this application for a Body Art Practitioner (must be within last 3 years)**
- **Provide proof of Hepatitis B vaccination, or declination of vaccination, WITH this application (may provide proof that a vaccination process has begun –** consult with a doctor about a test for titer or need for a booster if previous vaccination or booster was done more than 5 years ago**)**

Are you 18 or more years old? Yes ____ No _____ A Practitioner must be at least 18 years old.

SUMMARY – OF BODY ART FACILITY
CONSTRUCTION AND EQUIPMENT REQUIREMENTS
THE FOLLOWING APPLIES ONLY TO
BODY ART FACILITY PERMITTING – NOT PRACTITIONER

(This summary may not contain all facility construction or equipment requirements)

1. Does this Facility have smooth, durable, nonabsorbent, easily washable and disinfectable floors, walls, ceilings, countertops, chairs, procedure tables in workstation, restroom and cleaning areas?

   Yes _____ No _____ Explain ____

2. Does this Facility have potable hot water with a minimum temperature of 105° F supplied through hot/cold mixing faucets at all required sinks?

   Yes _____ No _____ Explain ____

3. Does this Facility have a restroom with a handwash sink with hot/cold mixing faucet and wall-mounted liquid soap and paper towel dispensers?

   Yes _____ No _____ Explain ____

4. Does this Facility have an easily accessible handwash sink with hot/cold mixing faucet and wall-mounted liquid soap and paper towel dispensers that are located in the workstation area(s)?

   Yes _____ No _____ Explain ____

5. Which of the following does this Facility utilize:
   a) All non-expired/dated pre-packaged, pre-sterilized, non-reusable items that are single-use and disposed of after each client: **OR**
   b) DEH approved Autoclave and Ultra-Sonic Cleaner separated from each other by a minimum of 36 inches and located in a designated cleaning area that is separated from all other areas by wall(s) that are extending from the floor to a minimum height of 8 feet and has an equipment-wash sink with hot/cold mixing faucet:

   Circle a) or b); Explain ____

6. If an Autoclave is used at this Facility, it must provide a minimum of 250 F for a specified period of time per the manufacturer. Does the Autoclave meet this requirement, including b) above?

   Yes _____ No _____ Explain ____

7. Will this Facility and all of the Practitioner(s) maintain and have current valid permits issued by DEH?

   Yes _____ No _____ Explain ____

8. Does this Facility have a waiting area that is separate from all other areas?

   Yes _____ No _____ Explain ____

9. Does this Facility have adequate ventilation and lighting (as determined by DEH)?

   Yes _____ No _____ Explain ____

10. Will all other required permits/clearances be obtained to operate or perform construction at this Facility? Yes _____ No _____ Explain ____

(For the purposes of this application, DEH means the Department of Environmental Health of Santa Clara County)

DEH may not be able to accept this application until the above requirements are sufficiently met

Signature: ____________________________________ Date ______________________________

Print Name: ____________________________________ Phone ______________________________