Town of Wallingford, Health Department
45 South Main St.
Wallingford CT 06492

Vanessa Bautista, RS, MPH
Director of Health

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DATE: _____

SALON & PERSONAL SERVICE ESTABLISHMENTS LICENSE APPLICATION

Name of Establishment:	**Name of Licensee/Operator *:**
Address of Establishment:	**Name of Business Owner:**
Mailing Address:	**Home Address:**
Business Phone #:	**Home/Cell Phone #:**
Fax #/Email:	**E-Mail:**

Annual License Fee - $50.00
Code of the Town of Wallingford, Chapter 173

- ☐ **Barber/Beauty Salon**
- ☐ **Nail Salon**
- ☐ **Permanent Make-up/Microblading**
- ☐ **Eyelash services**
- ☐ **Skin care, face/neck massage, waxing, eyebrow trimming, etc.**
- ☐ **Tattoo**

I HEREBY certify that I am the Licensee/Operator of the subject service establishment. **I understand that the establishment license is not transferable.** I further understand that future renovations must be reviewed and approved by the Health Department prior to the start of any construction. **The establishment license must be renewed annually by March 1st**

Signature: _____ (Print Name) _____

Corporation member names/titles: _____, _____

***All individuals rendering service that require CTDPH License must have proof of license at establishment**
****Only an MD or APRN can dispense or administer prescriptions (BOTOX is a prescription based application). A PA or RN must have written agreement with MD/APRN for oversight. CGS 19a-903c**
*****No food preparation permitted on site without a food service license.**

List all licensed technicians operating within the facility. All licenses must be verified.

1.	6.
2.	7.
3.	8.
4.	9.

***All individuals rendering service that require CT DPH License must have proof of license at establishment. (Provide copies of technician licenses)**

FOR OFFICE USE ONLY

Date License Issued _____

Amount/Date Fee Paid _____

Receipt#: _____