



City of Westfield, Massachusetts

HEALTH DEPARTMENT

APPLICATION FOR BODY ART ESTABLISHMENT PAGE 2

List below, name, address and telephone number of **ALL** body art practitioners working at the establishment:

NAME	ADDRESS	PHONE#
Practitioner 1		
Practitioner 2		
Practitioner 3		
Practitioner 4		
Practitioner 5		

AUTOCLAVE INFORMATION:

Autoclave Manufacturer: _____ Model # _____

Model Year: _____ Serial # _____

A drawing of the floor plan of the establishment (to scale) must accompany this application to qualify it for consideration.

I, the undersigned, acknowledge that I have received, read and understand the following:

- Westfield Board of Health Regulations pertaining to the practice of Body Art
- 1910.1030 OSHA regulations on blood borne pathogens
- 105 CMR 480.00 State Sanitary Code regulations on the storage and disposal of medical or biological waste
- Body Art disclosure statements and aftercare instructions.

Signature: _____

Date: _____

Please print name _____