



**BODY ART ESTABLISHMENT LICENSE APPLICATION
FOR CALENDAR YEAR 2021**

<p>This application will be rejected unless all questions are fully answered, proper remittance is attached, and Health Department approval is obtained. If your check is rejected by the bank due to insufficient funds, a license will not be issued until full payment is received. A check return fee of \$30.00 will be charged. All payments made subsequent to a check returned due to insufficient funds must be by cash, credit card, money order, or other certified funds acceptable to Tri-County Health Department.</p> <p>Mail remittance and application to: Tri-County Health Department 6162 S. Willow Drive, Suite 100 Greenwood Village, CO 80111</p>	<p>Health Department Approval</p> <p>Approved by: _____</p> <p>Date: _____</p>
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Owner/Account Information

Business Code

Individual / Sole Proprietor
 Corporation Partnership Limited Liability Company Local Agency / District
 County Agency State Agency Federal Agency Non-Profit 501(c)(3) [Please enclose copy of IRS letter of explanation] Other

Full legal name of corporation, individual owner, or non-profit:	Contact name:
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Owner Street #	Direction	Street Name	Street Type	Unit Type	Unit #
City		State	Zip	Owner Phone Number	
Owner Email Address					

Facility Information Address same as: Owner Address

Facility Name (Trade Name/DBA)

Street #	Direction	Street Name	Street Type	Unit Type	Unit #
City		State	Zip	Facility Phone Number	
Facility Email Address					

County: Adams Arapahoe Douglas

Send Invoices to: Owner/Account Record Facility Record

Mail Permit/License to: Owner/Account Record Facility Record

Hours of Operation: _____

Seasonal? Yes No

If seasonal, mark each business month: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

In consideration thereof, I do hereby certify that I have complied with all of the applicable regulations set forth in the Tri-County Health Department Regulations for Body Art Establishments ("Regulations"), and that I have complied with all orders given by authorized inspectors of Tri-County Health Department. I do hereby agree that in the event that the requirements of the Regulations are not complied with, I will discontinue advertising Body Art services and / or operating a Body Art Establishment, pursuant to the provisions of the Regulations, until such time as requirements are met.

Applicant's Signature	Title	Date
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<input type="checkbox"/> Body Art License.....\$345.00 <input type="checkbox"/> Body Art – Temp.....\$345.00	
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Additional Facility Information

Office: Admin. Aurora Castle Rock Commerce City

EHS Area #: _____

Sewer: Sewer District Septic Unknown Other

Water: Public Community Other Unknown Private Well Public Non-Community

Well Permit # (PWSID): _____

General Program Information (Body Art)

New Establishment Change of Owner Information Changes Only

OW# _____ FA# _____ AR# _____ PR# _____

Are other general health programs associated with this facility and owner? Yes No

Previous Owner Name: _____

Service Request #: _____

Program Details

Program Element (PE): _____

Designated (Assigned) Employee: _____

Program Type (Inspection Code):

Body Art

Uses sterilized and packaged autoclave equipment: Yes No Unknown N/A

Uses one-time use disposal equipment: Yes No Unknown N/A

Expiration Date: Permit is valid to: 12/31/_____

Comments/Pre-inspection Notes:

