

**ARKANSAS DEPARTMENT OF HEALTH  
COSMETOLOGY SECTION  
4815 West Markham, Slot 8  
Little Rock, AR 72205  
(501) 682-2168**

**MOBILE SALON CHANGE OF STATUS APPLICATION**  
**PLEASE PRINT USING BLUE OR BLACK INK**

**INSTRUCTIONS:** The purpose of this form is for any type of change of status to an existing mobile salon. **Refer to table below for required fee and instructions as to what sections of this application are required. Place an "X" in the box to indicate the type of application.**

**A DUPLICATE LICENSE WILL BE MAILED OUT IN APPROXIMATELY TWO (2) WEEKS.**  
**All fees are non-refundable**

**FEE CALCULATION TABLE**

(X)	<u>DESCRIPTION</u>	<u>AMOUNT DUE</u>	<u>SECTIONS TO BE COMPLETED</u>
	CHANGE NAME ONLY	\$25.00	SECTIONS: (A); (B); (D)
	CHANGE OWNER ONLY	\$25.00	SECTIONS: (A); (C); (D)
	CHANGE OWNER AND NAME	\$50.00	SECTIONS: (A); (B); (C); (D)

**SECTION (A) – MOBILE SALON INFORMATION CURRENTLY ON FILE WITH THE COSMETOLOGY SECTION (PRIOR TO CHANGE)**

Mobile Salon Name				Telephone Number ( )		
Address Where Mobile Salon Receives Mail		Suite #	City	County	State	Zip Code
Physical Address of Mobile Salon Primary Station when not in operation		Suite #	City	County	State	Zip Code
Type of Mobile Salon	COSMETOLOGY    MANICURE    ELECTROLOGY    AESTHETICS			ID NUMBER	LICENSE NUMBER	
Name of Owner (Corporation or Individual)						

**SECTION (B) – NEW MOBILE SALON NAME**

<b>NEW</b> Mobile Salon Name
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**DO NOT WRITE IN THIS AREA – FOR OFFICE USE ONLY**

DATE		ID NUMBER		RECEIPT	
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**SECTION (C) – NEW MOBILE SALON OWNER**

**This section requires a copy of the driver's license and a legal document, bill of sale or notarized statement from previous owner to support the change of ownership.**

Is the NEW owner a corporation?  YES      NO	If yes, name of corporation	If no, is new owner licensed?  YES      NO	Id number	License number
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**COMPLETE THE FOLLOWING INFORMATION REGARDING NEW OWNER.**

Last Name		First Name (no nicknames)			Middle Name		SSN		
Date of Birth	Gender MALE      FEMALE	Race	Black	White	Am. Indian	Hispanic	Asian	Alaskan Native	
Address Where You Receive Mail			Apt #	City		County	State	Zip Code	
Address Where You Live			Apt #	City		County	State	Zip Code	
Phone (    )		Email Address (REQUIRED)							

**SECTION (D) – OWNER CERTIFICATION**

In signing this application, you are certifying that:

1. The information provided on this form is correct to the best of your knowledge.
2. You are the mobile salon owner or are authorized to act as the owner's agent.
3. You have read this form, the laws and rules.
4. You have complied with all laws and rules governing cosmological establishments and mobile salons.
5. You will close your mobile salon if the inspector finds the mobile salon not in compliance with applicable rules.

Print Owner's Name	Owner's Signature	Today's Date
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DATE		ID NUMBER		RECEIPT	
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