

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

NEW ESTABLISHMENT REGISTRATION

INSTRUCTIONS: File this application when applying for a new establishment license. This form is to be filed approximately two (2) weeks before your opening date. You will receive a letter of authorization, to be posted in the reception area, which will allow you to open and operate said salon until such time it is inspected.

**THIS FORM MUST BE SUBMITTED WITH:
 \$100.00 NON-REFUNDABLE NEW ESTABLISHMENT FEE**

If requested information is not applicable, please respond with N/A

Establishment Name					Telephone Number	
Address Where Establishment Receives Mail		Suite #	City	County	State	Zip Code
Physical Address of Establishment		Suite #	City	County	State	Zip Code
Type of Establishment <input checked="" type="radio"/> COSMETOLOGY <input type="radio"/> MANICURE <input type="radio"/> ELECTROLOGY <input type="radio"/> AESTHETICIAN				Email Address		
Days Open (Check all that apply) <input type="checkbox"/> Sunday <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday					Opening Date	

Owner Information:

Is the owner a corporation? <input checked="" type="radio"/> Yes <input type="radio"/> No	If yes, name of corporation:	If no, is owner licensed? <input checked="" type="radio"/> Yes <input type="radio"/> No	License Number
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Complete the following information regarding the owner:

Last Name		First Name			Middle Name		
SSN	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Race <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Am. Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Alaskan Native				
Owner or Corporation Address		Apt. #	City	County	State	Zip Code	
Owner or Corporation Email address				Owner or Corporation Phone Number			

Owner's Signature	Today's Date
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By signing this application, I certify that the information provided is correct to the best of my knowledge, and I am the establishment owner or am authorized to act as the owner's agent. Further, I understand that false statements will be sufficient grounds for the Cosmetology Technical Advisory Committee to take disciplinary action. I have read this form, the laws and the rules and have complied with them during this process. In addition, I agree to close the establishment in the event that the Cosmetology Inspector determines that the establishment is not in compliance with the applicable laws and rules.