

**ARKANSAS DEPARTMENT OF HEALTH
BODY ART 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 establishment until such time it is inspected. Please make sure information is legible.

**THIS FORM MUST BE SUBMITTED WITH:
\$150 NON-REFUNDABLE NEW ESTABLISHMENT FEE**
If requested information is not applicable, please respond with N/A

Establishment Name					Opening Date (Required)		
Type of Establishment (Select One) <input type="checkbox"/> Fixed / Stand-Alone Location <input type="checkbox"/> Mobile Establishment		Will your establishment use an Autoclave? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, for what purpose: <input type="checkbox"/> Reuse items <input type="checkbox"/> Medical Waste (Must Register with ADH Medical Waste)				
Address Where Establishment Receives Mail			Suite #	City	County	State	Zip Code
Physical Address of Establishment			Suite #	City	County	State	Zip Code
Telephone Number				Email Address (Required)			
Days Open and Hours of Operation (Enter all that apply) Sunday: _____ Monday: _____ Tuesday: _____ Wednesday: _____ Thursday: _____ Friday: _____ Saturday: _____ By Appt Only: _____					Type of Establishment (Mark all that apply) <input type="checkbox"/> BODY ART <input type="checkbox"/> PIERCING <input type="checkbox"/> PERMANENT COSMETICS		

Complete the following information regarding the owner

Last Name (Required)		First Name (Required)		Is the owner a corporation or LLC? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, name of corporation or LLC	
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, Corporation or LLC Address		Apt. #	City	County	State	Zip Code
Owner, Corporation, or LLC Email address (Required)				Owner, Corporation, or LLC Phone Number		
Is owner Licensed? <input type="checkbox"/> YES <input type="checkbox"/> NO	If yes, License # (Required)	If no, Name of Licensed Artist on Staff	Artist License #	Artist Phone Number and Email Address		

Applicant Signature: 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 Inspector determines that the establishment is not in compliance with the applicable laws and rules.

Owner's Signature	Today's Date
Artist's Signature	Today's Date