

CROMWELL HEALTH DEPARTMENT

SALON APPLICATION: (NEW OR RENEWAL)

For Year: _____

Type of Establishment

(Check all that apply)

Barber Shop _____

Skin _____

Hair _____

Nail _____

Beauty Salon _____

Tanning _____

Days of Operation: _____

Hours of Operation: Monday _____

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

Saturday _____

Sunday _____

Name of Business: _____ Phone # _____

Location of Business: _____

Mailing Address: _____

Principal Owner's Name: _____ Phone # _____

Home Address: _____ Zip _____

Co-Owner: _____ Phone # _____

Address: _____ Zip _____

Manager's Name: _____ Phone # _____

Address: _____ Zip _____

Information to be attached:

- Copy of floor plan and equipment placement.
- Copy of written sterilization procedure for equipment and fixtures.
- Copy of Professional License (i.e. Hairdresser and Cosmeticians)

Cromwell Health Department
41 West Street, Cromwell, CT 06416
Tel.: (860) 632-3426
Fax: (860) 632-3477

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Your Rubbish/Trash Hauler: Name _____ Phone # _____

I hereon attest that the above is the truth and agree that the permit to which this application is made will at all times be operated in compliance with the terms of the General Statutes of the State of Connecticut, the Connecticut State Health Codes, local Ordinances, and orders of the Director of Health or his authorized Agent regarding all matters concerned with public health.

Signature _____ Name Printed _____

Date _____



Date Approved _____ Approved by: _____

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