

## Hall County Environmental Health

2875 Browns Bridge Road, Gainesville, Georgia 30504, Phone: (770)531-3973, Fax: (770)531-6767

### BODY ART ESTABLISHMENT APPLICATION

Name of Body Art Establishment: \_\_\_\_\_

Address of Body Art Establishment: \_\_\_\_\_  
Street City State Zip

Mailing Address: \_\_\_\_\_  
Street City State Zip

Business Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Number of stations: \_\_\_\_\_ Water Supply:  Public Water  Individual Well  EPD Permitted Well

Owner's Name: \_\_\_\_\_

Owner's Address: \_\_\_\_\_  
Street City County State Zip

Owner's Primary Phone #: \_\_\_\_\_ Owner's Alternate Phone #: \_\_\_\_\_

Name of Party Responsible for Fees: \_\_\_\_\_

Billing Mailing Address: \_\_\_\_\_  
Street City County State Zip

Authorized Agent Name: \_\_\_\_\_

Authorized Agent Phone #: \_\_\_\_\_ Authorized Agent Email: \_\_\_\_\_

Hours of Operation:  Mon. \_\_\_\_\_  Tues. \_\_\_\_\_  Wed. \_\_\_\_\_  Thurs. \_\_\_\_\_  
 Fri. \_\_\_\_\_  Sat. \_\_\_\_\_  Sun. \_\_\_\_\_

Water Supply:  Public Water  Other \_\_\_\_\_

Sewage Disposal:  Public Sewer  Septic System (Permit # \_\_\_\_\_)  Other \_\_\_\_\_

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#### Attachments:

- Attach documentation of spore destruction tests for the sterilizer, and the independent lab, which does them.
  - Attach a copy of your Driver's License or State I.D. (Owner and agent).
  - Attach a complete description of all body art procedures performed.
  - Attach a list of all instruments, types of sharps and all inks used for any and all body art procedures.
  - Attach a copy of all applications, medical releases, after care instructions, and paperwork you require the "client" to fill out.
  - Attach a copy of contaminated biomedical waste hauler contract
  - Attach a copy of the Operator/Technician Policy and Procedures outlining steps to be taken if the operator or technician pierces their own skin while performing a body art procedure.
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**Employee Information**

*\*No person shall practice body art procedures without first obtaining an operator permit from the Hall County Environmental Health Department  
\*Proof shall be provided to the Department that all operators/technicians have completed, within 7 months from the date of employment, the Hepatitis B vaccination series.*

Please list all employees and their duties:

1. Full Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date Employed: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Operator is:  Physician  RN  LPN  PA  Dr. of Osteopathy  Other

Dates and locations of previous operation: \_\_\_\_\_

Comments: \_\_\_\_\_

2. Full Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date Employed: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Operator is:  Physician  RN  LPN  PA  Dr. of Osteopathy  Other

Dates and locations of previous operation: \_\_\_\_\_

Comments: \_\_\_\_\_

3. Full Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date Employed: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Operator is:  Physician  RN  LPN  PA  Dr. of Osteopathy  Other

Dates and locations of previous operation: \_\_\_\_\_

Comments: \_\_\_\_\_

4. Full Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date Employed: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Operator is:  Physician  RN  LPN  PA  Dr. of Osteopathy  Other

Dates and locations of previous operation: \_\_\_\_\_

Comments: \_\_\_\_\_

5. Full Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date Employed: \_\_\_\_\_

Job Duties: \_\_\_\_\_

Operator is:  Physician  RN  LPN  PA  Dr. of Osteopathy  Other

Dates and locations of previous operation: \_\_\_\_\_

Comments: \_\_\_\_\_

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

By signing this document you hereby agree that all information contained within is accurate and true to the best of your knowledge and certifies that you have received a copy of the Rules and Regulations pertaining to Body Art for Hall County Georgia.



Brenda Fitzgerald, MD, Commissioner | Nathan Deal, Governor

2 Peachtree Street NW, 15th Floor  
Atlanta, Georgia 30303-3142  
www.health.state.ga.us

**GEORGIA DEPARTMENT OF PUBLIC HEALTH**  
Verification of Residency for Public Benefits  
O.C.G.A. Section 50-36-1(e)(2)

As part of my application for public benefits from the Georgia Department of Public Health, I hereby swear, under oath, that I am:

[check one of the following]

- (1) \_\_\_\_\_ A citizen of the United States;
  - (2) \_\_\_\_\_ A legal permanent resident of the United States;
- or
- (3) \_\_\_\_\_ A qualified alien or non-immigrant under the Federal Immigration and Nationality Act. The alien number assigned to me by the United States Department of Homeland Security or other federal immigration agency is Alien Number \_\_\_\_\_.

I also swear that I am eighteen years of age or older, and that I have provided at least one secure and verifiable identity document with this affidavit, as required by O.C.G.A. Section 50-36-1(e)(1). That secure and verifiable document is my

\_\_\_\_\_  
\_\_\_\_\_.

In making these representations, I understand that any person who knowingly and willfully makes a false statement in an affidavit on any matter within the jurisdiction of state government shall be guilty of a violation of O.C.G.A. Section 16-10-20 and face the criminal penalties authorized by that statute.

\_\_\_\_\_  
Signature of Applicant

Subscribed and sworn before me  
this \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Printed Name of Applicant

\_\_\_\_\_  
Notary Public  
My commission expires \_\_\_\_\_.