

# Hall County Environmental Health

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

## BODY ART OPERATOR/TECHNICIAN APPLICATION

### Applicant Information

Applicant's Full Name: \_\_\_\_\_ Sex:  F  M

Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Mobile #: \_\_\_\_\_ Work #: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

*(The body art operator/technician must be a minimum of 18 years of age.)*

### Attachments:

- Attach a copy of your Driver's License or State I.D.
- Attach proof of attendance to a Bloodborne pathogen training program (or equivalent), given or approved by this department.
- Attach a copy of your Immunization Record.
- Residency Verification

### Medical Information

Have you been immunized against Hepatitis B:  Yes. Attach proof of the Hepatitis B vaccination series.  
 No. Date proof submitted: \_\_\_\_\_

*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.*

Do you have any of the following:  Boils  Infected wounds  Open sores  Abrasions  
 Keloids  Weeping dermatological lesions  Acute respiratory infection

*The application should be submitted once you are free of any of the above rashes or infections. No person or operator affected with any of the above shall work in any area of a body art establishment in any capacity in which there is a likelihood that person could contaminate body art equipment, supplies, or working surfaces with body substances or pathogenic organisms.*

### Employment

*It shall be unlawful for any person to perform body art procedures unless such procedures are performed in a body art establishment with a current permit.*

Current Body Art Establishment Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Street Address: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Date Employed: \_\_\_\_\_

Current Job Title: \_\_\_\_\_ Job Duties: \_\_\_\_\_

Please list any training, experience, or certifications that would demonstrate your knowledge of anatomy, skin diseases, infectious disease control: \_\_\_\_\_

### Employee Information

Please list the previous place of employment as a Body Art Operator, duties and responsibilities, address, phone number of establishment, and length of time employed.

Establishment Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Street Address: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Length Employed: \_\_\_\_\_

Duties and Responsibilities: \_\_\_\_\_

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 \_\_\_\_\_.