CHESPROCOTT HEALTH DISTRICT
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Maura A. Esposito RS, MPH, Director of Health

Barbershops, Hairdressers, Cosmetology, Nail Salon Plan Review Application

Please fill out this form completely. The following items must be submitted with the application to be a complete submission:

- One (1) copy of the entire facility layout drawn to scale (1/4" = 1 foot). This layout should include:

    1. Locations of all stations (including but not limited to hair sinks, utility sinks, hand sinks, and chemical sinks).
    2. A complete set of equipment specifications, numbered on the specification sheet to correspond with numbers provided on floor plan. The equipment model numbers must be identified on the specification sheet.
    3. A copy of each State issued license as well as a copy of that individual's driver's license.
    4. A list of all provided services.

Allow a time frame of **7-10 business days** for our office to review and respond to your submission.

*See fee schedule under "Cosmetology Licensing Fee". Fee should be submitted with application. *

☐ New Establishment ☐ Conversion ☐ Remodel of existing establishment ☐ Change of Ownership

Establishment:

Name of Establishment: _____

Address (including town, state, zip code): _____

Phone number: _____

Email address: _____

Owner of Establishment:

Name of Establishment: _____

Address (including town, state, zip code): _____

Phone number: _____

Email address: _____

Type of Business: Please mark all that apply.

□ Barbershop □ Nail Salon □ Hairdressing □ Cosmetology □ Esthetics

Sewage Disposal/Water Supply: Please mark all that apply.

□ Public Sewer □ Public Water

□ Septic □ Private Well

Estimated Daily Water Usage (only for those who are on **septic**): _____

Establishment Details:

Is this establishment an **in-residence** shop? Yes/No If yes, specify location: _____

Square Footage of Facility: _____

Are food or drinks being provided? Yes/No If yes, specify: _____

Hours of Operation:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Number of Chairs: _____ Number of Stations: _____

Number of hair sinks: _____ Number of Bathrooms: _____

Establishment Maintenance:

Sanitizer/Disinfectant

Type: _____ Concentration: _____

EPA Registration Number: _____

Laundry

☐ Onsite (washer and dryer **required**)

Onsite – sanitizer used: _____

☐ Off-site laundry services

Off-site – must provide contract or receipts.

Ventilation (Nail Salons)

Type: _____

Location(s): _____

Additional Notes:

Office Use Only

Revisions Needed: _____

Plan Approved: _____

Date

By: _____

Revised 02/01/2023