



*Commonwealth of Virginia*  
**Chesapeake Health Department**  
**Division of Environmental Health**  
 748 North Battlefield Boulevard  
 Chesapeake, VA 23320  
 (757) 382-8672 Fax (757) 382-8713

Office Records
Date Received: _____
\$1200 Annual Permit: _____

## Body Art Establishment Permit Application

**\*\* Please fill out application entirely. \*\***

Application fee \$1,200; Make checks payable to *Chesapeake Health Department*.

**Purpose:**  New Establishment  Renewal  Name Change  Owner/Corporation Change

**Name of Establishment:** \_\_\_\_\_  
 Facility Address: \_\_\_\_\_ Suite # \_\_\_\_\_  
 Facility Phone: \_\_\_\_\_ Email address: \_\_\_\_\_  
 Billing Address: \_\_\_\_\_

**Hours of Operation:** Sun \_\_\_\_\_ Mon \_\_\_\_\_ Tues \_\_\_\_\_ Wed \_\_\_\_\_ Thurs \_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_  
**Months of Operation:** Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

**Water Supply:** (check appropriate box)  Public- Name \_\_\_\_\_ or  Private- Type \_\_\_\_\_  
**Sewage:** (check appropriate box)  Public- Name \_\_\_\_\_ or  Private- Type \_\_\_\_\_

**Name of Owner:** \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_

**Establishment owner is a/an:**  Association  Corporation  Individual  Partnership  Other Legal Entity

**Association, Corporation, Partnership name:** \_\_\_\_\_

**Person directly responsible for the establishment:**

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_  
**Telephone:** \_\_\_\_\_

Practitioner Name	Credentials	Status
	<input type="checkbox"/> Red Cross certification in first aid and blood borne pathogens <input type="checkbox"/> Hepatitis B testing <input type="checkbox"/> TB test/risk assessment	<input type="checkbox"/> Owner/practitioner <input type="checkbox"/> Contractor <input type="checkbox"/> Employee
	<input type="checkbox"/> Red Cross certification in first aid and blood borne pathogens <input type="checkbox"/> Hepatitis B testing <input type="checkbox"/> TB test/risk assessment	<input type="checkbox"/> Owner/practitioner <input type="checkbox"/> Contractor <input type="checkbox"/> Employee
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	<input type="checkbox"/> Red Cross certification in first aid and blood borne pathogens <input type="checkbox"/> Hepatitis B testing <input type="checkbox"/> TB test/risk assessment	<input type="checkbox"/> Owner/practitioner <input type="checkbox"/> Contractor <input type="checkbox"/> Employee

I/we attest to the accuracy of the information provided, affirm to comply with the City of Chesapeake Code of Ordinances, Chapter 38 and allow the regulatory authority access to the establishment at any reasonable time to inspect, conduct tests or collect samples as required.

Applicant's Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Applicant's Name (printed): \_\_\_\_\_

Date: \_\_\_\_\_

**For Official Use:**

Census Tract: \_\_\_\_\_

Environmental Health Spec. \_\_\_\_\_

Issue Date: \_\_\_\_\_

Expiration Date: \_\_\_\_\_