COUNTY OF SANTA CLARA
DEPARTMENT OF ENVIRONMENTAL HEALTH
1555 Berger Drive #300 San Jose, CA 95112
(408) 918-3400 Phone - (408) 280-6479 Fax
swpadmin@cep.sccgov.org
www.sccwaste.org

OFFICIAL USE ONLY

FACILITY ID#	
RECEIPT#	
AMOUNT PAID	
DATE PAID	

PERMANENT BODY ART FACILITY APPLICATION

TYPE OF SERVICE:	TYPE OF PERMIT:
☐ TATTOO ☐ BODY PIERCING ☐ PERMANENT COSMETICS ☐ BRANDING	☐ BODY ART FACILITY | FEE = $400 | PE = 4705

MAKE CHECKS PAYABLE TO COUNTY OF SANTA CLARA DEH

FACILITY

Name of Facility
(Please Print) _____

Site Address _____ City _____ State _____ Zip _____

Phone _____ Website _____

Are you a facility owner and practitioner? ☐ YES ☐ NO

Are you registered as a practitioner in Santa Clara County? ☐ YES ☐ NO

IF YES, provide your practitioner registration number here: FA# _____

Are you updating information? ☐ YES ☐ NO

ADDITIONAL DOCUMENTATION REQUIRED :

☐ DEH Plan Check Completed Date of final inspection: _____ Inspector: _____

☐ Infection Prevention and Control Plan

Have there been any changes or revisions to your Infection Prevention and Control Plan? ☐ YES ☐ NO

OWNER

Owner Name _____ Cell Phone _____

Owner Address _____ City _____ State _____ Zip _____

Owner Email _____

Billing Address _____ City _____ State _____ Zip _____

PRACTITIONERS

The facility owner must keep an updated list of practitioners and notify DEH of status changes within 30 days. Attach additional sheets if necessary.

FA#	COUNTY ISSUED	PRACTITIONER NAME	FA#	COUNTY ISSUED	PRACTITIONER NAME

I hereby certify that all statements made in this application are true and correct. I agree to operate in accordance with all applicable state and local regulations regarding The Safe Body Art Act (California Health and Safety Code commencing with Section 119300) and Santa Clara County Ordinance Code B11. I agree to maintain a current Infection Prevention and Control Plan and a facility that meets or exceeds all requirements.

Signature _____ Date _____

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☐ NEW FACILITY ☐ UPDATE ☐ CHANGE OF OWNERSHIP (previous owner's name) _____

PREVIOUS NAME OF FACILITY/BUSINESS _____

COMMENTS _____

FACILITY ID # _____ DESIGNATED EMPLOYEE _____

☐ APPROVED ☐ DISAPPROVED

BY _____ EMP# _____ DATE _____ SUPERVISOR _____ DATE _____