



Northeast District Department of Health

69 South Main Street, Unit 4

Brooklyn, CT 06234

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<p><i>Sanitarian Approved</i></p> <p><i>Initial:</i> _____</p> <p><i>Date:</i> _____</p> <p><i>Emailed:</i> _____</p>

SERVICE APPLICATION

COSMETOLOGY: _____ BARBER: _____ NAIL SALON: _____ OTHER: _____

Name of Establishment: _____

Business Street Address: _____ Town: _____

Legal Owner of Business: _____

Billing Email: _____

Mailing Address for Business: _____

Town: _____ State: _____ Zip: _____ Business Tel: _____

Manager Name: _____

Mailing Address: _____

Town: _____ State: _____ Zip: _____ Tel: _____ Fax: _____

.....

Number of Workstations/Chairs: _____ Business Hours: _____

Sewage Disposal: Public: _____ Private: _____ Date Last Pumped: _____

Water Supply: Public: _____ Private: _____ Date Last Tested: _____

List all operators below including name, license type, and license number with expiration date.
(Attach additional sheets if necessary)

Signature of Owner/Operator: _____ Date: _____

Name:	Type of License:	License Number:	Employee or Independent Contractor
_____	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/> <input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/> <input type="checkbox"/>

<i>NDDH Use Only</i>							
<i>Date:</i> _____	<i>Fee:</i> _____	<i>Check #</i> _____	<i>CC</i>	<i>E-Check</i>	<i>Cash</i>	<i>Receipt #</i> _____	
<i>Date:</i> _____	<i>Fee:</i> _____	<i>Check #</i> _____	<i>CC</i>	<i>E-Check</i>	<i>Cash</i>	<i>Receipt #</i> _____	