



Application Number: _____

Date: _____

Boston Public Health Commission Body Art Practitioner License Application

Type of Application

- New application Resubmission Renewal Temporary Apprentice
 Tattoo Piercing Other Body Arts (Specify) _____

Practitioner Information

| | | |
|-----------------------------|--------------|------------|
| First Name: | Middle Name: | Last Name: |
| Address: | | |
| City: | State: | Zip Code: |
| Phone number () | - | |
| Social Security Number: | | |
| Date of Birth (MM/DD/YYYY): | Sex: | |

Workplace/Establishment Information

| | | |
|--|-----------------------------------|--|
| Name of Establishment: | | |
| Address : | | |
| City: | State: | Zip Code: |
| Phone number () | - | |
| Fax Number () | - | |
| Body Arts practiced at the Establishment: | | |
| <input type="checkbox"/> Tattoo | <input type="checkbox"/> Piercing | <input type="checkbox"/> Other Types (Specify) |
| Certificate of Occupancy Date and Number (provide a copy): | | |

Required documents

| | |
|---|--|
| Identification Card Copy (At least on is required – attach copy) | |
| <input type="checkbox"/> Massachusetts Driving License License Number: | <input type="checkbox"/> State Identification Card Card Number: |
| <input type="checkbox"/> Passport Number and Expiration date: | <input type="checkbox"/> Other (Specify) |

Required for all Body Art Practitioners

(attach copies of documentation)

Education and Training including evidence of course completion or certification in:

- Body Art Practitioner License (issued by BPHC) Number: _____ Valid Until: _____
- First Aid / CPR Date of Certificate: _____
- Prevention of Disease Transmission and Bloodborne Pathogens Date of Completion: _____
- Documentation of Prior Experience (Document two years if possible) _____
Date _____ Name and Address _____

From: _____ To: _____

- 1)
- 2)
- 3)
- 4)
- 5)

Valid Body Art Practitioner License or Certificate from other City, or State

- Required of all Practitioners of Non-Tattoo Body Art**
Anatomy & Physiology Course Date of Completion: _____

MEDICAL HISTORY OF ANY COMMUNICABLE DISEASES:

Have you ever been diagnosed with:

- Hepatitis Tuberculosis

Have you been immunized against Hepatitis B?

- Yes No

Provide a list for each of the following:

Current state of health _____

Any physical disabilities _____

(Office Use Only)

Knowledge and or experience in or about:

- Sterile Conditions
- Workstation Requirement
- Sterilization Procedures (Provide example)
- Client and Practitioner Health Related information
- The Body Art Regulation of the Boston Public Health Commission

Applicant Statement of Consent

I understand that this license is valid only in the City of Boston and expires two years after the date that it is issued. I further understand that I must have a valid license to practice in the City of Boston and that the license is only valid for the conduct of those body art practices for which I have applied, as listed on the license. I also understand that any notice to be mailed to me by the Boston Public Health Commission will be mailed to my address indicated on this application and a copy of such notice will also be mailed to the operator of the Body Art Establishment that I have indicated above.

I have received a copy of the Boston Public Health Commission Body Art Regulations. I have read and understand the obligations and requirements imposed upon a licensed Body Art Practitioner by those regulations. I also agree to comply with all of the regulation requirements specified in the Boston Public Health Commission Body Art Regulations while practicing in the City of Boston.

I hereby certify, under penalties and pains of perjury, that to the best of my knowledge the information provided on this application is complete and accurate and in no way misrepresented.

Signature of the applicant: _____

Date: _____

Full Name: _____

Please include a business check or money order (we cannot accept cash, credit cards, or personal checks) with your application in the amount of \$200 to cover the permit fee.