UNCAS HEALTH DISTRICT

PLAN REVIEW
APPLICATION FOR A SALON OR BARBERSHOP

Facility Information			**Owner/Representative Information**		
Name of Facility			Name of Corporation, Organization or Individual		
Contact Person			Contact Person		
Email Email will be the main form of communication to establishment			Email		
Telephone			Telephone		
Physical Address			Address		
City	State	Zip	City	State	Zip
Mailing Address (if different from above)			Mailing Address (if different from above)		
City	State	Zip	City	State	Zip

Operator (if different than owner)	
Email Email will be the main form of communication to establishment	Alternate Email
Telephone	Alternate Telephone

Type of Establishment
(check all that apply)

Hairdressing *		Cosmetology	
Barbering		Nail Technology	

* See Regulations Section 1.1 Definitions for "Hairdressing and Cosmetology"

Services Offered
(check all that apply)

Cosmetology		Massage		Esthetics/Facials		Other (Please Explain)
Hairdressing		Manicures		Eyebrow Arching		
Hair Cutting		Pedicures		Eyelash Extensions		
Braiding Hair		Foot Baths		Threading		
Waxing		Tanning		Microblading		

Days/Hours of Operation

Monday _____ to _____ Wednesday _____ to _____ Friday _____ to _____ Sunday _____ to _____

Tuesday _____ to _____ Thursday _____ to _____ Saturday _____ to _____

Continued on Back

Salon Information

	Quantity	
Total Number of Chairs		
Total Number of Stations		
Total Number of Hand Sinks		**See Regulations Section 1.12 Equipment and Facilities**
Licensed Hairdresser/Cosmetician		**Please include all CT Licensed employees working in establishment**
Licensed Barber		
Nail Technician		
Nail Technician Trainee		
Eyelash Technician		
Esthetician		
Massage Therapist		
Tattoo Technician		

Type of Disinfection

(Check all that apply)

Quaternary Ammonium		Lysol		Alcohol		*Other EPA Registered Disinfectants	
Boiling Water		Commercial Formalin		Lubricant Sanitizer			

*Please Specify

UV Light is Not an Approved Method of Disinfection

Water Supply

(Indicate source in appropriate box below)

Source	
Registered Public Supply	
PWSID #	
Private Well *	

Sewage Disposal

(Indicate Type in the appropriate box below)

Public Sewer	
Septic System *	

* Please submit a copy of the most recent water test (Must be taken with in last 3 months) and a copy of latest pump out for septic system

Floor Plans

A copy of the floor plan must be submitted with the plan review. **(See Regulations Attachment A)**

Signatures

Owner/Representative Name (please print)

Owner/Representative Signature

Date

For District Use Only:

Fee Paid _____

Date _____

Cash _____

Check/MO _____

Credit Card _____

Receipt No. _____

Fees

A non-refundable plan review fee of $100.00.

Make check or money order payable to:

Uncas Heath District
401 West Thames Street, Suite 106
Norwich, CT 06360

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