

APPLICATION FOR SKIN PENETRATION, BEAUTY THERAPY PREMISES

NAME OF APPLICANT: _____

ADDRESS: _____ POST CODE: _____

PHONE: _____ FAX: _____ MOBILE: _____

ADDRESS OF BUSINESS:

NAME OF BUSINESS: _____ ABN: _____

STREET NO: _____ STREET _____

SUBURB: _____ POST CODE: _____

PHONE: _____ FAX: _____

TYPE OF BUSINESS: (Please tick all boxes applicable)

Home occupation Mobile Commercial

TYPE OF ACTIVITIES: (Please tick all boxes applicable)

General Beauty Therapy Body Waxing Massage

Acupuncture Skin Piercing Shaving

Tattooing Facials and/ or microdermabrasions Electrolysis

Manicures and/ or pedicures Acrylic nails Ear- or nose-piercing

Lancing (i.e. removal of blackheads, ingrown hairs etc) Make-up application

Eye lash and eye brow (tinting/ extension) Solarium/ tanning booth

Other activities: _____

FACILITIES: (Please circle)

Hot water service provided: YES/ NO

Laundry facilities: Available on the premises / taken home for washing

Refreshments provided? (e.g. complimentary drinks/ food for clients): YES*/ NO

*Food business must be notified under the Food Act 2008.

QUALIFICATIONS/ TRAINING: _____

PLEASE NOTE: the following 3 information items must be provided in writing with this application or it will not be processed.

Copy of the internal fittings detailed layout showing the locations of the following:

1. procedures area e.g. for waxing, tattooing, massage etc (please indicate the type of floor covering, walls, ceiling, shelves, fittings and any other furniture present);
2. hand free type hand wash basin supplied with hot and cold water, soap and paper towels in the immediate treatment area;
3. sink designated for cleaning and decontaminating equipment only;
4. work space and preparation area (separate from treatment areas);
5. work stations;
6. instruments and equipment storage area;
7. preparation area for refreshments;
8. general waste and medical wastes receptacles;
9. natural/mechanical ventilation (e.g. windows, evaporative air-conditioner outlet etc).

Details of sterilisation equipment(s) to be used (if applicable)

Please include the following details:

- Equipment brand name and model no.
- Type (autoclave/ dry heat)
- Specifications (temperature, pressure and time)
- Details of calibration including certificate of calibration
- Details of maintenance including servicing details and log sheets

Disinfection and/ or sterilisation plan

OFFICE USE

Health Application Number: _____

CS/CA Officer: _____

There are currently no fees relating to a Skin Penetration Establishment

