

Town of Wallingford, Connecticut

HEALTH DEPARTMENT

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Director of Health

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DATE: _____

SALON ESTABLISHMENTS LICENSE APPLICATION

(Barbershop, Hairdressing, Cosmetology, Nail Salons & Tattoo/Body Piercing)

Name of Establishment:	Name of Licensee/Operator:
Address of Establishment:	Name of Business Owner:
Mailing Address:	Home Address:
Business Phone #:	Home/Cell Phone #:
Fax #/Email:	E-Mail:

Annual License Fee is Determined by Services Rendered , Under Salon Ordinance No. 592

- Barber/Salon.....\$ 50.00 *
- Nails\$100.00
- Salon/Nails/Permanent Make-up\$100.00
- Tattoo..... \$100.00

I HEREBY certify that I am the Licensee/Operator of the subject service establishment. **I understand that the salon license is not transferable.** I further understand that future renovations must be reviewed and approved by the Health Department prior to the start of any construction. The salon license must be renewed annually by March 1st..

Signature: _____ **(Print Name)** _____

Corporation members: _____

***If corporation, include name of officer/title.**

❖ **Permit fee of \$50 for Baber/Beauty Salon NOT providing other services as listed**



Public Health
Prevent. Promote. Protect.