



**CITY OF NEW BEDFORD HEALTH DEPARTMENT**  
**1213 Purchase St. New Bedford, MA 02740**  
**508-991-6199**

\*\*\*\*\*  
**ANNUAL BODY ART ESTABLISHMENT/ PRACTITIONER ADVISORY**  
\*\*\*\*\*

Dear Licensee:

On June 30<sup>th</sup> licenses to operate a Body Art Establishment **and/or** to Practice Body Art will expire.

The fee for an annual practitioner's license is \$200.00 and the annual establishment license fee is \$250.00. All applications for renewal received after **June 1st** will be subjected to late filing fees (20% of license fee).

If you are an **“Establishment” owner/operator renewal candidate;**

- Submit **proof of liability and worker's comp coverage** with your application.
- On your application, please remember to provide tax information, sign and date.
- Attach all required documentations.

If you are a **“Practitioner” renewal candidate:**

- Evidence of active professional liability insurance in limits not less than 1MM/3MM.
- Proof of a routine medical examination taken no later than twelve months prior to the application
- Copy of a current first aid / cardiopulmonary resuscitation (CPR) certification.

Payment for permit must be made in the form of a check, money order or postal note payable to the City of New Bedford, cash is not accepted.

All applications must be filed at or mailed to:

**City of New Bedford Health Department**  
**1213 Purchase Street – 1<sup>st</sup> fl**  
**New Bedford, MA 02740**

If you have any questions or require further assistance, please contact the Health Department @ (508) 991-6199. This will be your only reminder. Thank you for your cooperation.

Very truly yours,

New Bedford Board of Health





# NEW BEDFORD BOARD OF HEALTH APPLICATION FOR BODY ART LICENSE

Fee Paid: \_\_\_\_\_

Check#: \_\_\_\_\_

Receipt#: \_\_\_\_\_

Initial Application     Renewal Application     Amendment Request

Application Type:  Body Art Practitioner     Body Art Establishment     Body Art Apprentice  
 Guest Artist     Piercer     Dermal Piercer     Cosmetic Tattooing

## **PART 1: IDENTIFICATION**

Name: \_\_\_\_\_ Tel. \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

List the establishment name, address, telephone number, and the owner and the operator's name (if different), for each Body Art Establishment where applicant's Body Art will be provided:

<u>Establishment</u>	<u>Owner &amp; Operator</u>	<u>Address</u>	<u>Telephone</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____

## **PART II: BODYART PRACTINIONERS AND OPERATORS ONLY** (fill in where applicable)

### **CREDENTIALS**

<u>Program/Course/Organization</u>	<u>Dates Attended</u>	<u>Successfully Completed?</u>
<u>Name &amp; Location</u>	<u>Dates Attended</u>	<u>Yes/No</u>
Blood borne Pathogens: _____	_____	_____
First Aid and CPR: _____	_____	_____
Anatomy: _____	_____	_____
Skin Disease/Disorders: _____	_____	_____
Dermal Piercing training: _____	_____	_____
Cosmetic/ Microblading Training: _____	_____	_____

✓ Attach copies of your certificates of completion, including course hours and description.

List Certifications or Licensure from regulatory agencies, municipalities and /or states, now or formerly held:

\_\_\_\_\_ (✓ attach copy of certificate or license)

\_\_\_\_\_ (✓ attach copy of certificate or license)

List Professional Body Art Association Membership:

\_\_\_\_\_ (✓ attach copy of certificate or license)

\_\_\_\_\_ (✓ attach copy of certificate or license)

### **TRAINING AND EXPERIENCE (Practitioners, Apprentices and Guest Artist)**

List the establishment names, locations and telephone numbers, and the operators' names, of the organizations where you have been involved in the provision of Body Art in the past 5 years:

---



---



---



---

Have you ever had a license to provide Body Art or a license to operate a Body Art Establishment suspended or revoked? Yes  (provide details); No

---

Have you ever been convicted of a felony? Yes  No

Have you been convicted of misdemeanor in the last five years? Yes  No

(√ If your answer to either of the forgoing questions is yes, attach a separate sheet with complete details including when, where, for what offense, in which court, and with what sentence. Note that you are not required to furnish information for any offense committed prior to your 17<sup>th</sup> birthday.)

Provide the name, address, telephone number and relationship of three references:

<u>Reference Name</u>	<u>Address</u>	<u>Telephone</u>	<u>Relationship to Applicant</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

**Attach the following documentation to this application:**

- A face-front picture and copies of two forms of positive identification (birth certificate, passport, etc.).
- Proof of active professional liability coverage.
- Proof of a routine medical examination by a physician within 12 months of this application.
- Proof of a negative skin test result for tuberculosis taken no later than 60 days prior to application.

**PART III: BODY ART ESTABLISHMENT APPLICATIONS ONLY**

List names of each Practitioner who will provide Body Art at this Establishment:

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

Establishment Days and Hours of Operation: \_\_\_\_\_ Number of Employees: \_\_\_\_\_

Provide a complete description of all Body Art procedures to be performed in the Establishment:

---

**Attach the following documentation to this application: (for new establishments only)**

- A floor plan, drawn to scale of the Establishment
- The manufacturer, model no., model year and serial no. of the autoclave(s) to be used in the Establishment
- Material Safety Data Sheets for each ink or dye to be used in the Establishment.
- Proof of a contract to provide proper disposal of medical waste and sharps.
- Signed acknowledgement of Tattoo Regulations

**PART IV: ATTESTATION**

*I certify under penalty of perjury that the information contained in this application is complete and truthful. I authorize the City of New Bedford, its agents and the employees to conduct an investigation into the truthfulness of the information contained herein and further authorize the release of any pertinent information regarding my education, past employment or background. I also attest that I have read and intend to comply with the Board of Health Regulations governing Body Art and understand that the discovery of false or inaccurate information in this application could result in the suspension or revocation of any license which may be issued by the Board of Health.*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Tax ID #: \_\_\_\_\_ Type:  FEIN or  SSN

\_\_\_\_\_  
(Date)

Board of Health  
City of New Bedford  
1213 Purchase St  
New Bedford, MA 02740

To Whom it may concern:

I hereby certify that \_\_\_\_\_(name) was seen in our office for examination on \_\_\_\_\_ (date) and found to be in a good health. I am sending report of my findings and recommendations directly to you, including a report from a certified laboratory of a serological (blood serum) examination for all communicable diseases, TB and a report of a chest X-ray, in connection with his/her application for a body art practitioner's (or Body Art establishment) license in New Bedford.

Yours truly,

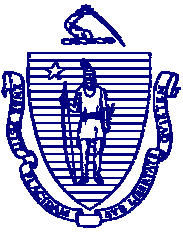
\_\_\_\_\_, M.D./D.O  
(Name of Physician)

\_\_\_\_\_  
(Office Location)

\_\_\_\_\_  
(City/Town, Zip Code)

\_\_\_\_\_  
(Telephone)





The Commonwealth of Massachusetts  
 Department of Industrial Accidents  
 Office of Investigations  
 600 Washington Street  
 Boston, MA 02111  
 www.mass.gov/dia

**Workers' Compensation Insurance Affidavit: General Businesses**

**Applicant Information**

**Please Print Legibly**

Business/Organization Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Are you an employer? Check the appropriate box:**

- 1.  I am a employer with \_\_\_\_\_ employees (full and/or part-time).\*
- 2.  I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
- 3.  We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]\*\*
- 4.  We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

**Business Type (required):**

- 5.  Retail
- 6.  Restaurant/Bar/Eating Establishment
- 7.  Office and/or Sales (incl. real estate, auto, etc.)
- 8.  Non-profit
- 9.  Entertainment
- 10.  Manufacturing
- 11.  Health Care
- 12.  Other \_\_\_\_\_

\*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.

\*\*If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

**I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.**

Insurance Company Name: \_\_\_\_\_

Insurer's Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Policy # or Self-ins. Lic. # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).**

Failure to secure coverage as required under Section 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to \$1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to \$250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

**I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone #: \_\_\_\_\_

*Official use only. Do not write in this area, to be completed by city or town official.*

City or Town: \_\_\_\_\_ Permit/License # \_\_\_\_\_

**Issuing Authority (circle one):**

- 1. Board of Health
- 2. Building Department
- 3. City/Town Clerk
- 4. Licensing Board
- 5. Selectmen's Office
- 6. Other \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

# Information and Instructions

Massachusetts General Laws chapter 152 requires all employers to provide workers' compensation for their employees. Pursuant to this statute, an **employee** is defined as "...every person in the service of another under any contract of hire, express or implied, oral or written."

An **employer** is defined as "an individual, partnership, association, corporation or other legal entity, or any two or more of the foregoing engaged in a joint enterprise, and including the legal representatives of a deceased employer, or the receiver or trustee of an individual, partnership, association or other legal entity, employing employees. However, the owner of a dwelling house having not more than three apartments and who resides therein, or the occupant of the dwelling house of another who employs persons to do maintenance, construction or repair work on such dwelling house or on the grounds or building appurtenant thereto shall not because of such employment be deemed to be an employer."

MGL chapter 152, §25C(6) also states that "**every state or local licensing agency shall withhold the issuance or renewal of a license or permit to operate a business or to construct buildings in the commonwealth for any applicant who has not produced acceptable evidence of compliance with the insurance coverage required.**" Additionally, MGL chapter 152, §25C(7) states "Neither the commonwealth nor any of its political subdivisions shall enter into any contract for the performance of public work until acceptable evidence of compliance with the insurance requirements of this chapter have been presented to the contracting authority."

---

---

## Applicants

Please fill out the workers' compensation affidavit completely, by checking the boxes that apply to your situation and, if necessary, supply your insurance company's name, address and phone number along with a certificate of insurance. Limited Liability Companies (LLC) or Limited Liability Partnerships (LLP) with no employees other than the members or partners, are not required to carry workers' compensation insurance. If an LLC or LLP does have employees, a policy is required. Be advised that this affidavit may be submitted to the Department of Industrial Accidents for confirmation of insurance coverage. **Also be sure to sign and date the affidavit.** The affidavit should be returned to the city or town that the application for the permit or license is being requested, **not** the Department of Industrial Accidents. Should you have any questions regarding the law or if you are required to obtain a workers' compensation policy, please call the Department at the number listed below. Self-insured companies should enter their self-insurance license number on the appropriate line.

---

---

## City or Town Officials

Please be sure that the affidavit is complete and printed legibly. The Department has provided a space at the bottom of the affidavit for you to fill out in the event the Office of Investigations has to contact you regarding the applicant. Please be sure to fill in the permit/license number which will be used as a reference number. In addition, an applicant that must submit multiple permit/license applications in any given year, need only submit one affidavit indicating current policy information (if necessary). A copy of the affidavit that has been officially stamped or marked by the city or town may be provided to the applicant as proof that a valid affidavit is on file for future permits or licenses. A new affidavit must be filled out each year. Where a home owner or citizen is obtaining a license or permit not related to any business or commercial venture (i.e. a dog license or permit to burn leaves etc.) said person is NOT required to complete this affidavit.

The Office of Investigations would like to thank you in advance for your cooperation and should you have any questions, please do not hesitate to give us a call.

---

---

The Department's address, telephone and fax number:

The Commonwealth of Massachusetts  
Department of Industrial Accidents  
**Office of Investigations**  
600 Washington Street  
Boston, MA 02111

Tel. # 617-727-4900 ext 406 or 1-877-MASSAFE

Fax # 617-727-7749

[www.mass.gov/dia](http://www.mass.gov/dia)