

Hair Dressing and Skin Penetration Premise Application Form



Health Services

Business Details:

Name of Premise (in full):		
Address of Premise:		
Postal Address (if different from above):		
Phone: Business Hours	A/Hours	Fax
Email:		
Registered Business Name:		
ABN/ACN:		
Postal Address of Head Office (if part of a franchise chain or similar):		
Phone: Business Hours	A/Hours	Fax
Details of any other associated premises:		
Name of person in charge and title (if different from proprietor):		
Languages spoken: <input type="checkbox"/> English <input type="checkbox"/> Other (specify):		
Number of equivalent full time staff:		

Proprietor Details:

Name of Proprietor/s (in full):		
Postal Address:		
Proprietors Driving Licence No:	Date of Birth:	
Phone (Home):	(Mobile):	Fax:
Email:		

Nature of Business Please tick the applicable boxes):

- | | |
|---|--|
| <input type="checkbox"/> Hairdressing | <input type="checkbox"/> Electrolysis |
| <input type="checkbox"/> Tattooing | <input type="checkbox"/> Manicure |
| <input type="checkbox"/> Permanent Eyebrow/Lip lining | <input type="checkbox"/> Pedicure |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Spray Tan |
| <input type="checkbox"/> Ear Piercing | <input type="checkbox"/> Solarium (Sun Bed) |
| <input type="checkbox"/> Body Piercing (including branding, scaring etc,) | <input type="checkbox"/> Other (Please give details) |
| <input type="checkbox"/> Wax Depilation (Waxing) | |

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Level of disinfection and sterilisation of appliances: (Please tick the applicable boxes)

- NON-CRITICAL PROCEDURE= Appliance may come into contact with intact skin but does not penetrate skin or come into contact with mucosa or blood (Cleaning Required). **
- SEMI-CRITICAL PROCEDURE= Appliance may come into contact with mucosa or blood (Disinfection Required). **
- CRITICAL PROCEDURE= Appliance enters or penetrates the skin. Cleaning and sterilisation required. **

Please provide a brief summary/outline of the cleaning, disinfection or sterilisation procedures undertaken: _____

** If you are unsure of the correct procedures for cleaning, disinfecting or sterilising appliances, please read Part 4 (pages 9-11) - SELECTION AND MANAGEMENT OF APPLIANCES from the **Code of Practice for Skin Penetration Procedures**.

Type of sharps disposal (if applicable) _____

What sort of training programs do you have in place for staff in regards to hygiene, health and safety? _____

Hours of operation:

Monday		Friday	
Tuesday		Saturday	
Wednesday		Sunday	
Thursday			

Floor Plan

Please provide a floor plan layout of your proposed premise with this application, showing the location of fixtures such as hand basins and sinks, and include details on the materials used in the premise for shelving and flooring.

Further Information

- Department of Health Website: www.public.health.wa.gov.au
- City of Wanneroo Health Services: Telephone 9405 5000

Please allow up to 14 days for application to be processed.

Declaration:



I, the person making this application declare that:

- The information contained in this application is true and correct in every particular.
- I enclose an amount of \$290.00 being the non-refundable application fee and initial inspection fee.

Signature of applicant: _____

In the case of a company, the signing officer must state position in the company

Date: _____

Credit Card Payments (please note, payments by credit card incur a surcharge of 0.57% (inc GST))			
 <input type="checkbox"/>	 <input type="checkbox"/>		
Name on Card:			Expiry Date:
Card Number:	<input type="text"/>	<input type="text"/>	<input type="text"/> \$290.00
Signature:			Date: