

**STATE OF NEBRASKA**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 Division of Public Health – Licensure Unit
 P.O. Box 94986, Lincoln, Nebraska 68509-4986
 402-471-4359 inna.karpyuk@nebraska.gov

Application for a Body Art Facility License

Effective 12/01/2008; revised 10/2009
 Print or Type

It is your responsibility to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

SECTION A - GENERAL INFORMATION (All applicants must complete this section) **This section is public information and will be displayed on the INTERNET at <http://www.nebraska.gov/LISSearch/search.cgi>**

<input type="checkbox"/> NEW FACILITY		FEE: \$150.00 \$37.50 if your license is issued within 180 days of the expiration date		
1	Name of Facility:			
2	Address:	Street/PO/Route:		
		City:	State:	Zip:
3	Telephone Number:			
4	Owner(s) Name:			

<input type="checkbox"/> OWNER CHANGE		FEE: \$150.00 \$37.50 if your license is issued within 180 days of the expiration date		
1	Name of Facility:			
2	Address:	Street/PO/Route:		
		City:	State:	Zip:
3	Telephone Number:			
4	Name of NEW OWNER (s):			

<input type="checkbox"/> NAME CHANGE		FEE: \$10		
1	Previous Name of Facility:			
2	Address:	Street/PO/Route:		
		City:	State:	Zip:
3	NEW NAME of Facility:			
4	Name of Owner(s):			

<input type="checkbox"/> LOCATION CHANGE		FEE: \$150.00 \$37.50 if your license is issued within 180 days of the expiration date		
1	Name of Facility:			
2	NEW ADDRESS:	Street/PO/Route:		
		City:	State:	Zip:
3	Telephone Number:			
4	Name of Owner(s):			

NOTE: Licenses expire March 31st of odd numbered years.

Make payable to "Licensure Unit"

Additional information requested – All applicants must complete the following information
 (This information is not displayed on the internet)

1	Address of the Owner of the Business	Street/PO/Route:											
		City:	State:	Zip:									
2	If the applicant is a sole proprietorship , identify the social security number of the owner (this is REQUIRED INFORMATION) Social security numbers obtained under this section shall not be public information but may be shared by the department for administrative purposes if necessary and only under appropriate circumstances to ensure against any unauthorized access to such information.			SS #:									
3	Federal Identification Number (FIN) (in the event a refund is warranted)			FIN#:									
4	Business Phone #: (optional)	Business Fax #: (optional)	Owner/Business E-Mail Address: (optional)										
5	Name of each Person in Control of the Business (if space is not adequate, attach additional sheet)												
<p>Indicate the type of owner of this business:</p> <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Sole proprietorship</td> <td><input type="checkbox"/> Limited liability company that has more than one member</td> </tr> <tr> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> Corporation</td> </tr> <tr> <td><input type="checkbox"/> Limited 1 liability company that has only one member</td> <td><input type="checkbox"/> Governmental unit</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other: Identify Type _____</td> </tr> </table>						<input type="checkbox"/> Sole proprietorship	<input type="checkbox"/> Limited liability company that has more than one member	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation	<input type="checkbox"/> Limited 1 liability company that has only one member	<input type="checkbox"/> Governmental unit		<input type="checkbox"/> Other: Identify Type _____
<input type="checkbox"/> Sole proprietorship	<input type="checkbox"/> Limited liability company that has more than one member												
<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation												
<input type="checkbox"/> Limited 1 liability company that has only one member	<input type="checkbox"/> Governmental unit												
	<input type="checkbox"/> Other: Identify Type _____												

SECTION B – OPERATION INFORMATION (All applicants must complete this section)

1	Anticipated Opening Date:				
2	Hours Facility Is Open Daily:	Sunday	_____ am	to	_____ pm
		Monday	_____ am	to	_____ pm
		Tuesday	_____ am	to	_____ pm
		Wednesday	_____ am	to	_____ pm
		Thursday	_____ am	to	_____ pm
		Friday	_____ am	to	_____ pm
		Saturday	_____ am	to	_____ pm

Check here if open by appointment only

NOTE: If the facility is not identified by a street address, please provide directions to the facility on the reverse side of this form.

SECTION C – FLOOR PLAN

For **NEW APPLICATIONS AND CHANGE OF LOCATION**, you must attach a floor plan of the facility, which includes an indication of the restroom(s), sinks, and any connecting building/living space.

