



STATE OF NEBRASKA

Division of Public Health – Licensure Unit
301 Centennial Mall South - P.O. Box 94986
Lincoln, Nebraska 68509-4986 (402-471-4977)
vicki.nelson@nebraska.gov

**APPLICATION TO OPERATE A
COSMETOLOGY SALON**

License #:
Issued:
Expires:

10/2013

FEE: \$150.00

Make payable to: LICENSURE UNIT

PLEASE PRINT OR TYPE

Check the appropriate licensure type(s) below (CHECK ALL THAT APPLY):

Application due to salon renewal expiration

Home Salon **OR** Commercial Salon

Barber Area (Check this box if the salon also has a barber area and contact the Board of Barber Examiners for licensure of this area)

Change of Location; Will the former location be closed when new location becomes operational? YES NO

Change of Ownership; Identify the former owner(s): _____

SECTION A - GENERAL INFORMATION (All applicants must complete this section)

| | | | | | |
|---|---|---|----------|------|----------|
| 1 | NAME OF ESTABLISHMENT: | | | | |
| 2 | ESTABLISHMENT ADDRESS: | Street/PO/Route: | | | |
| | | City: | State: | Zip: | |
| | | NOTE: If the establishment is not identified by a street address, please provide directions. | | | |
| 3 | TELEPHONE NUMBER: | | | | |
| 4 | NUMBER OF LICENSEES TO BE WORKING AT ANY ONE TIME: | | | | |
| 5 | ANTICIPATED OPENING DATE: | | | | |
| 6 | HOURS SALON 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

BUT MUST LIST DAYS AND TIMES MOST LIKELY TO BE WORKING

SECTION B - SKETCH and INSURANCE--All applicants MUST submit the following documents

1. A **sketch** of the salon premises; and
2. A copy of the **minimal property damage, bodily injury, and liability insurance** coverage for the salon.

SECTION C - OWNER INFORMATION (All applicants must complete the following information--this information is not displayed on the internet)

Indicate the type of owner of this business:

Sole proprietorship
 Partnership
 Limited 1 liability company that has only one member
 Limited liability company that has **more than one** member

Corporation
 Governmental Unit
 Other: Identify Type _____

SOLE PROPRIETORSHIP OR PARTNERSHIP:

| | | | | | | |
|---|---|------------------|----------------------------|--|---|--|
| 1 | Full name of the Business Owner(s) or Partners: | | | | | |
| 2 | Address of the Business Owner(s): | Street/PO/Route: | | | | |
| | | City: | State: | | Zip: | |
| 3 | 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 #: | |
| 4 | Business Phone #: (optional) | | Business Fax #: (optional) | | Owner/Business E-Mail Address: (optional) | |

CORPORATION OR LIMITED LIABILITY COMPANY OR GOVERNMENT UNIT:

| | | | | | | |
|---|--|------------------|----------------------------|--|---|--|
| 1 | Name of Corporation, LLC, or Government Unit: | | | | | |
| 2 | Mailing address of the Business Owner(s) or corporate office. This should be an address different from the salon address: | Street/PO/Route: | | | | |
| | | City: | State: | | Zip: | |
| 3 | Federal Identification Number (FIN or EIN required in the event a refund is warranted) | FIN (EIN) #: | | | | |
| 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) | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

SECTION D – PRACTICE PRIOR TO CREDENTIAL (All applicants must complete the following information)
An individual who practices prior to issuance of a credential is subject to assessment of an Administrative Penalty of \$10 per day up to \$1,000, or such other action as provided in the statutes and regulations governing the credential.

| | | |
|---|---|--|
| 1 | Have you operated this business at this address in Nebraska prior to the application for a license? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2 | Have you operated this business at this address in Nebraska after the expiration date of your salon license? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3 | If yes, what are the actual number of days you operated: | # of days: _____ |

SECTION E - ATTESTATION (All applicants must complete the following information)

I hereby state that I am the person making application, I am of good character, and the statements on this application are true and complete. I further state:

If the applicant is a sole proprietorship for the purpose of complying with Neb. Rev. Stat. §4-108 through 4-114, the applicant must attest as follows:

- I am a citizen of the United States.
- I am a qualified alien under the Federal Immigration and Nationality Act.

My immigration and alien number are as follows: _____ and I agree to attach a copy of my USCIS documentation, which includes one of the following:

1. A "Green Card" otherwise known as a Permanent Resident Card (Form I-551), both front and back of the card;
2. An unexpired foreign passport with an unexpired Temporary I-551 stamp bearing the same name as the passport;
3. A document showing an Alien Registration Number ("A#"), an Employment Authorization Card/Document is **NOT** acceptable;
4. A Form I-94 (Arrival-Departure Record).

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States.

The application must be signed by the individual(s) indicated below (place a check mark in the appropriate box) and dated:

- 1. The owner or owners if the applicant is a sole proprietorship, a partnership, or a limited liability company that has only one member;
- 2. Two of its members if the applicant is a limited liability company that has more than one member;
- 3. Two of its officers if the applicant is a corporation;
- 4. The head of the governmental unit having jurisdiction over the business if the applicant is a governmental unit; or
- 5. If the applicant is not an entity described in 1 through 4 above, the owner or owners or, if there is no owner, the chief executive officer or comparable official.

**HAVE YOU PREVIOUSLY HELD A COSMETOLOGY OR NAIL TECHNOLOGY SALON LICENSE IN NEBRASKA?
IF YES, IDENTIFY THE NAME AND LOCATION:**

NAME: _____ **LOCATION:** _____ (street)
_____ (city)

Signature of Owner/Representative as listed above

Date

Signature of Owner/Representative as listed above

Date

Inspection: As part of the application process, we are asking you to complete a self-inspection of your salon (see attached self-inspection report). Please submit this application and inspection report to the Department at the address identified on page 1.

Cosmetology Salon Self-Inspection Report

Department of Health & Human Services



Division of Public Health
 Licensure Unit
 P.O. Box 94986
 Lincoln, Nebraska 68509
 (402) 471-4977

| | |
|-------------------|--------------|
| Salon Name: _____ | |
| Address: _____ | |
| Town: _____ | |
| Owner: _____ | Tele # _____ |

Column A: (Indicate "N/A" for Areas not applicable) Yes/No **Column B:** (Indicate "N/A" for Areas not applicable) Yes/No

| STRUCTURE | | DISINFECTION & DISINFECTANT SOLUTION STORAGE | |
|---|-----|---|--|
| 1. Walls, Ceiling & Furniture clean & in good repair | | 27. Disinfectant Solution | |
| 2. Lighting clean/safe/in working order | | Solution covered at all times | |
| 3. Floors clean & free of unsafe objects/uneven surfaces | | Manufacturer's mixing directions followed | |
| 4. Windows clean and safe | | Changed when visibly cloudy/dirty and at least once per week | |
| 5. Ventilation System and/or Fans | | Solution is EPA registered | |
| a. Fan clean | | Name of disinfectant used: _____ | |
| b. Ceiling vents clean | | 28. Immersion Disinfection process followed | |
| c. System/Fan Safe | | Remove foreign matter | |
| d. Ventilation/open window/fan | | Wash hands | |
| e. Air flow set to "ON" or "CONTINUOUS" | | Wash implement with hot water/soap | |
| 6. Electrical appliances clean and safe/no bare wires (blow dryer, curling iron, clippers, wax machines, etc) | | Thoroughly rinse implement in water | |
| 7. Flammable/combustible chemicals stored away from potential sources of ignition | | Place implement in EPA solution | |
| 8. Chemicals stored in closed bottles/containers | | Wash hands before removing implement | |
| 9. Cabinets, drawers, containers used for storage of implements/towels are clean | | Rinse implement in water | |
| 10. Unused supplies are stored in clean, enclosed container/drawer | | Air dry/dry with clean towel/electric air | |
| 11. Implements that have not been used on a client/soiled are placed in a labeled covered container until disinfected | | Place in clean enclosed container | |
| 12. Cloth towels deposited in closed receptacle after use | | 29. Spray Disinfection process followed (metal implements, clippers) | |
| 13. Used/soiled towels not used again until properly laundered and sanitized | | Remove foreign matter | |
| 14. Disposable towels discarded in closed waste receptacle with a plastic liner immediately after use | | Wash hands | |
| 15. Chemicals (except deodorizers) in locked cabinets | | Spray implement until totally saturated with EPA solution | |
| 16. Clean and operational toilet and sink | | 30. No formaldehyde vapor nor ultra-violet ray treatment procedures used in lieu of immersion/spray disinfection | |
| 17. Suitable holders for toilet paper | | BLOOD SPILL PROCEDURES | |
| 18. Clean waste receptacle, with disposable plastic liner | | 31. Client injury procedure followed | |
| 19. Hot and cold running water | | 32. Licensee injury procedure followed | |
| 20. Liquid Soap | | 33. No Styptic pencils used | |
| 21. Single-use disposable towels/appropriate clean holder | | PRODUCTS | |
| 22. Clean, including washer & dryer | | 34. Liquids, creams, etc kept in clean closed containers | |
| 23. Closed receptacle for storing soiled towels | | 35. Original bottles have original manufacturer labels | |
| 24. Used for establishment laundry only/no personal items | | 36. All product bottles labeled | |
| 25. Licensee washes/sanitizes hands before service | | 37. Product removed with spatula, scoop, pump, etc | |
| 26. Gloves free of tears/changed gloves if contaminated | | SUPPLIES & MATERIALS | |
| AUTOMATIC UNSATISFACTORY RATING is given if a YES is marked in any of the following: | | 38. Neck strips/clean towel used under cape – sanitized or disposable cape (1per client) may be used in lieu of these | |
| A. Intoxicating Beverages/Controlled Substance on premises | Yes | No | |
| B. Pets in Establishment (aquariums/guide animals acceptable) | | | |
| C. Unlicensed persons providing services | | | |
| D. Unlicensed Establishment | | | |
| E. Denied access to all salon areas, personnel, records | | | |
| F. Establishment in an Inoperable Condition (i.e. remodeling) | | | |
| HAIR REMOVAL WAX | | | |
| 41. Wax removed from machine with clean applicator | | | |
| 42. Wax machine clean | | | |

INSPECTION RATING: SATISFACTORY UNSATISFACTORY

Date of Self-Inspection: _____ Signature of Salon Owner or Manager: _____

THIS INSPECTION REPORT MUST BE POSTED FOR PUBLIC VIEWING

(CONTINUED ON next page)

