Office use only

Form 3A

PO Box 54, Claremont, WA, 6910

APPLICATION TO ESTABLISH A SKIN PENETRATION, BEAUTY THERAPIST OR HAIRDRESSING ESTABLISHMENT

1. APPLICANT DETAILS

Surname:_____ First Name:_____

Proprietor or Company Director Name:_____

Company/Business Name:_____

Postal Address:_____

New Premises Address: _____

Postcode:_____ E-mail:_____

Mobile:_____ Telephone:_____

ABN/ACN:_____

Date of qualifications (please attach copy of qualification):_____

Please indicate procedures carried out on premises:

☐Hairdressing ☐Barber ☐Beauty therapy ☐ Pedicure

☐Manicure ☐ Facial waxing ☐Body waxing ☐Tanning

☐Acupuncture ☐Electrolysis ☐Tattooing ☐Ear piercing

☐Body piercing ☐Scarring

☐Other (please specify)_____

2. FACILITIES:

Number of work station(s):_____

Number of hair/hand wash basin(s):_____

Sink designated for cleaning and equipment: YES/ NO (circle)

Hot water service provided: YES/ NO (circle)

Laundry facilities: On premises / taken home (circle)

Approval for a mobile hairdresser shall only be granted to a person who is a qualified hairdresser and the following conditions:

1. The applicant must be a resident of the Town of Claremont
2. The applicant must be registered with the Town of Claremont Health Services.
3. The applicant has satisfied all requirements of Council's Town Planning Scheme.

Application checklist **(tick all applicable items required to be submitted with this application)**
Declaration at end of page MUST to be signed by applicant.

Copy of the internal fittings detailed layout showing the locations of the following:

- ☐ Hairdressing area (please indicate the type of floor covering, walls, ceiling, shelves, fittings and any other furniture present);
- ☐ Work stations and hand wash basins;
- ☐ Sink designated for cleaning and decontaminating equipment only;
- ☐ Instruments and equipment storage area;
- ☐ Natural/mechanical ventilation (e.g. windows, evaporative air-conditioner outlet etc).

All premises requiring statutory inspections as identified under the Act are charged an annual surveillance fee charged at the start of each financial year.

Applications may take up to 10 working days to process, it is therefore the applicants responsibility to ensure that the application is submitted with enough time to ensure that all approvals are granted in time.

Declaration:
I, the person making this application declare that:

- The information contained in this application is true and correct in every particular

Signature of applicant: _____ **Date** _____

Name of applicant: _____
In the case of a company, the signing officer must state position in the company

4. PAYMENT METHOD
Please indicate your preferred method of payment (*call 92854300 to pay by phone):
- ❑ Cheque (please make payable to the Town of Claremont)
- ❑ Money Order (please make payable to the Town of Claremont)
- ❑ Credit card (Visa or Mastercard only)

NOTE: For security reasons, the Town of Claremont Health Services **cannot accept written credit card details**.

Therefore, please provide the name as displayed on your credit card, and sign below to **authorise** the Town of Claremont to **debit** that credit card for $150.00.

The Town of Claremont will contact you to obtain your **credit card number.**

Name on Card: _____

Signature: _____ **Date:** _____

Privacy
The personal information collected on this form will only be used by the Town of Claremont for the sole purpose of providing requested and related services. Information will be stored securely by the Town and will not be disclosed to any third parties without your express written consent.

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