Town of Wallingford Health Department

45 South Main Street, Room 215, Wallingford, CT 06492
Phone: 203-294-2065; Fax: 203-294-2064
Email: healthclerk@wallingfordct.gov

Director of Health:
Vanessa Bautista,
MPH, R.S.

PERSONAL SERVICES ESTABLISHMENT LICENSE APPLICATION

Date: _____

Name of Establishment: _____

Address of Establishment: _____

Mailing Address of Establishment: _____

E-Mail: _____ **Business Phone #:** _____

Name of Licensee/Operator*: _____ **Home/Cell #:** _____

Name of Business Owner: _____

*All individuals rendering service that require CTDPH License must have proof of license at establishment

Annual License Fee – $50.00
Code of the Town of Wallingford, Chapter 173
****Check All Applicable Services Provided by Your Establishment****

- ☐ **Barber / Hair Dresser**
- ☐ **Cosmetics / Make-Up**
- ☐ **Esthetics (Skin Care, Waxing, Eyebrows, Neck & Face Massage)**
- ☐ **Nails (Cuts, Shapes, Polishes, Artificial Nail Application & Removal, etc.)**
- ☐ **Eyelash Services (Extensions, Lifts, Perms, Color Tints, etc.)**
- ☐ **Tattoo / Body Piercing**
- ☐ **Permanent Make-Up / Microblading**
- ☐ **Massage (Body Massage)**
- ☐ **Medical Spa* (Cosmetic Medical Procedures, Botox Injections, Hair Transplants, etc.)**

***Any Medical Spa must be evaluated to ensure compliance with state regulations. An MD, PA, or APRN must be employed or contracted by a Medical Spa to comply with state regulation. CGS 19a-903c**

No food preparation permitted on site without a separate food service license.

List ALL Technicians Operating Within This Facility. All Licenses MUST Be Verified

	Name	License #	Phone #	Email
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

I HEREBY certify that I am the Licensee/Operator of the subject service establishment. **I understand that the establishment license is not transferable.** I further understand that future renovations must be reviewed and approved by the Health Department prior to the start of any construction. **The establishment license must be renewed annually by March 1st**

Signature: _____ **Print Name:** _____

Corporation member names/titles: _____

FOR OFFICE USE ONLY

Date License Issued: _____

Type of Establishment: _____

Amount/Date Fee Paid: _____

Public Health
Prevent. Promote. Protect.