RI Department of Health

Licensing Application

and instructions for a

Body Piercing Establishments

Licensee Name: _____

Licensee Number: _____

Reason for application (Please check all that apply):

☐ Initial Licensure

☐ Change of address:
Enter current license number here:_____

☐ Change of ownership: What is your current license
Enter current license number here:_____

☐ Licensee Name Change

FOR OFFICE USE ONLY
Application Approved:
License Number:
Issue Date:
Supervisor Review:
Signature of Board Administrator
ID#:
Receipt #:

State of Rhode Island and Providence Plantations
Department of Health

INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Incomplete forms will be returned to you and your license will not be renewed. Please use a ballpoint pen.
- The fee for this application is $90.00
- Make your check/money order payable to "General Treasurer, State of Rhode Island". Do not send cash.
- Sign the completed application, return it with the required fee and mail to:

  Rhode Island Department of Health
  3 Capitol Hill, Room 306
  Providence, RI 02908-5097.

- If you have any questions concerning this renewal application, call the office of **Facilities Regulations** at (401) 222-2566.
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

You must attach a current printed list of all direct and indirect owners whether individual partnership, limited partnership, limited liability company, or corporation with percent of ownership. If a corporation, this list must also include all officers, directors and other persons of any subsidiary corporation owning stock.

Attachments: If you have been requested to submit attachment(s) with this application, please label and staple each separate attachment and securely affix any and all attachments to this application.

Postage: The amount of postage required for mail delivery will vary depending upon the total weight of your attachment(s) and application. Please be careful to include the appropriate postage necessary to mail your completed application.

Please review the information below from your last renewal and make changes as appropriate:

Additional Documentation: Please submit the following documentation with this application	a) Written proof that owner and/or operator is at least 18 years of age b) Criminal convictions of corporation, owner and/or manager, if any, except minor traffic violations (Background check) c) A list of all equipment d) A floor plan of the Body Piercing Establishment showing compliance with sink requirements e) Appropriate certificates of compliance with all local (Town/City) and State codes and Rhode Island Department of Health Regulations: https://rules.sos.ri.gov/regulations/Part/216-40-10-14 f) Written policies and procedures which include: hours of operation, nature of services, sanitation protocols and safety procedures including the practice of body piercing, infection control, a written exposure control plan and Hepatitis B vaccination policy
License Sub-Type: Please select one	☐ Profit ☐ Non-Profit
Body Piercing Technician or Physician: State licensure regulations require that the person engaged in the practice of body piercing must be either a Body Piercing Technician or a Physician licensed by the State of RI.. Please supply the name and RI license number of the Body Piercing Technician or Physician who will be working at this facility.	Name: _____ License Number: _____

State of Rhode Island and Providence Plantations
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Facility Name: Please provide the name of the facility (as known to the public) for which you are renewing this license.	Name: _____
Facility Contact Person: Please provide the name and telephone number of a person we can contact concerning this facility.	Name: _____ Phone Number: ( ) _____
Facility Mailing Information: Please provide the mailing information for all communication regarding this license. (**Not published on HEALTH website**).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Address Country _____ Phone: _____ Fax: _____ Email Address: _____
Facility Location Information: Please provide the location information for this facility. (**Published on HEALTH website**).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip Code _____ Address Country _____ Phone: _____ Fax: _____ Email Address: _____
Ownership Type: Please check ONE	☐ Corporation ☐ Governmental Entity ☐ Partnership ☐ Partner ☐ Limited Liability Company ☐ Sole Proprietorship ☐ Limited Partnership
Ownership Information: Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name: _____ DBA: _____

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Ownership Address Information: Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip code _____ Phone: _____ Fax: _____ Email Address: _____
Parent Organization, Group Affiliation: Please complete this section if there is any parent organization, group affiliation or other entity that is on the top of the Facility/agency control	Corporation Type _____ Name of Organization _____ Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip code _____ Phone: _____ Fax: _____ Email Address: _____
Land/Building Info: If the owner of the land and building is other than the operator of this agency/facility, please complete the following:	Name: _____ Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, Zip code _____ Phone _____
Compliance with Conditions of Approval Please check yes or no.	This facility/agency is in compliance with all conditions of approval (i.e. relative to Certificate of Need, Change of Effective Control, Initial Licensure and/or Licensure renewal). ☐ Yes ☐ No

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Acknowledgements

I am aware of Chapter 23-1-39 of the General Laws of Rhode Island, 1956, as amended, and the standards, rules and regulations prescribed thereunder, which regulate the operation of this facility.

I acknowledge that authorized representative of the Licensing Agency shall, in conformity with the authority continued under Chapter 23-1-39 of the General Laws of Rhode Island, as amended, have the right to enter without prior notice to inspect the entire premises and services, including all records of any facility/residence.

FEIN Number:

(Federal Employer Identification Number)

Note: If you are a sole proprietor this number may be your Social Security Number.

Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.

Please provide below SSN/FEIN for this license:

SSN/F.E.I.N. Number: _____

Affidavit of Applicant

Read, sign, and date this affidavit.

AFFIDAVIT AND SIGNATURE

This Application Must be Signed

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.

I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.

_____

Signature of Authorized Person

Date of Signature (MM/DD/YY) _____

_____

Printed Name of Authorized Person

_____

Title of Authorized Person

Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.