



TORRINGTON AREA HEALTH DISTRICT

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"Promoting Health & Preventing Disease Since 1967"

LICENSE FEE _____
PAID YES NO
(Returned Check Fee \$25)

APPLICATION FOR BEAUTY SALON OR BARBER SHOP LICENSE

- License Renewal Operational Change Change of Ownership New Business

PLEASE PRINT:

NAME OF BUSINESS _____ NUMBER OF STATIONS _____

STREET ADDRESS _____ TOWN _____ ZIP CODE _____

ESTABLISHMENT PHONE # _____ FAX # _____

Please Indicate Business Mailing Address If Different From Above:

MAIL TO _____ STREET ADDRESS _____

TOWN _____ STATE _____ ZIP CODE _____ PHONE _____ FAX _____

NAME OF MANAGER / OWNER _____ PHONE _____

STREET ADDRESS _____ TOWN _____

STATE _____ ZIP CODE _____

HOURS OF OPERATION

TYPE OF OPERATION

- BEAUTY SALON
 BARBER SHOP
 OTHER _____

WATER SUPPLY (check one)

- PUBLIC WATER
 PRIVATE WELL

SEWAGE DISPOSAL (check one)

- PUBLIC SEWERS
 SEPTIC SYSTEM

MONDAY _____

TUESDAY _____

WEDNESDAY _____

THURSDAY _____

FRIDAY _____

SATURDAY _____

SUNDAY _____

Date of the last water sample taken _____
(Please include copy of report)

I have enclosed the appropriate licensing fee of \$ _____

APPLICANT'S SIGNATURE

DATE