



Board of Health
 212 Main Street
 Northampton, MA 01060
 Tel: (413) 587-1214 • Fax: (413) 587-1221
 Director of Public Health: Merridith A. O'Leary, R.S.

FOR BOARD OF HEALTH USE ONLY	
Amt Received:	_____
Cash/Check No:	_____
Received by:	_____
Workers Comp Affidavit	<input type="checkbox"/>
CPR Certification	<input type="checkbox"/>
First Aid Certification	<input type="checkbox"/>
Float Sign Off	<input type="checkbox"/>

2019 APPLICATION FOR PERMIT TO OPERATE A FLOTATION THERAPY ESTABLISHMENT

PERMIT FEE: \$250.00 ANNUAL: **ALL FEES PAID ARE NON-REFUNDABLE**
NO PERMITS WILL BE ISSUED IF TAXES ARE OWED

Pursuant to MGL Chapter 62C, section 49A, I certify under the penalties of perjury that, to my best knowledge and belief, complied with the law of the Commonwealth relating to taxes, reporting of employees and contractors, and withholding and remitting child support.

Application is hereby made for a permit to operate a special purpose pool. This special purpose pool is to be operated according to the minimum standards of 105 CMR 435.000 Chapter V: Minimum Standards for Swimming Pools/ Special Purpose Pools & the Standards of Practice of a Flotation therapy Establishment that is set forth by the Northampton Board of Health.

Establishment Name: (dba): _____ Establishment Tel.#: _____

Establishment Address: _____

Mailing Address: _____

Email Address: _____

Applicant Name and Title: _____

Applicant Address: _____ Applicant Telephone #: _____

Owner Name & Title (if different from applicant): _____

Owner Address: _____

REQUIRED-CPR AND FIRST AID FOR ALL STAFF

Please include a copy of CPR and First Aid Certification (s) with this permit and list staff below:

Water Source: Public Well Sewage Disposal: Public Well

Number of Flotation Tanks	
Length	
Width	
Volume	
Treatment System (Kinds of Filters, ect)	
Disinfection Method (Type, capacity, ect)	
Chemical Treatment (Feeders, capacity, quantity)	

Signature of Applicant or Corporate Signature: _____

PLEASE MAKE ALL CHECKS PAYABLE TO THE CITY OF NORTHAMPTON

This form **must** be initialed and signed by the owner of the establishment applying for or renewing a Board of Health Flotation Therapy Establishment Permit.

No permit will be issued until this checklist has been initialed and signed.

Name of Establishment: _____

Owner: _____

_____ **I understand** that all on-site attendants shall have a valid First Aid and CPR certificate from an approved program and shall be maintained and kept on-site for verification.

_____ **I will** provide the Northampton Health Department with proof of current First Aid and CPR certificates.

_____ **I understand** that effective means of two way communication must exist between the attendant and each float room to provide emergency assistance to the patron at all times.

_____ **I understand** that a First Aid kit must be kept on-site.

_____ **I understand** that an emergency telephone must be available by staff or patrons to make emergency calls.

_____ **I understand** that all patrons under 17 years of age must be accompanied by an adult.

_____ **I understand** that each patron will receive written and/or verbal safety use procedures to the tank

_____ **I understand** that there will be a minimum of one sign with the rules.

_____ **I understand** that all design and construction must be approved by Northampton Health Department.

_____ **I understand** that skimmers, drains, and general design of the flotation tank must be VGBA compliant.

_____ **I understand** that the recirculation system shall operate continuously, except for when the tank is utilized during a float session.

_____ **I understand** that turnover rate must allow a minimum of three turnovers between each patron.

_____ **I understand** that chemical labeling, storing, mixing, and handling shall meet the requirements according to 105 CMR 435.

_____ **I understand** that chemical feeders shall meet the requirements according to 105 CMR 435.

_____ **I understand** water quality levels for disinfectant, pH, alkalinity, temperature, and combined chlorine when chlorine is used as the disinfectant must be measured and recorded a minimum of three times a day.

____ **I understand** that float tanks use alternative disinfection systems must have water samples submitted to a certified lab every 2 weeks for testing for Coliform, Pseudomonas and Heterotrophic Plate Count for the first 6 months and once a month thereafter or as the Health Department requires.

____ **I understand** all water sample results and daily testing logs must be maintained and available for review by the Health Department.

____ **I understand** water source shall meet the requirements according to 105 CMR 435.

____ **I understand** that all construction, installation, expansion and/or remodel will require the plans and specifications to stamped and designed by a Massachusetts Registered Professional engineer or Massachusetts Registered Sanitarian and approved by the Board of Health

____ **I understand** water levels shall be maintained according to manufacturer's instructions of the float tank.

____ **I understand** the saline solution within the tank should be completely replaced with fresh water and salt a minimum of every twelve months or if the solution becomes cloudy, exhibits an unusual odor, or has been contaminated with fecal matter or vomit.

____ **I understand** the closing criteria in 105 CMR 435 must be followed.

____ **I understand** the interior of the float tank shall be cleaned and sanitized with an approved sanitizer a minimum of once per week and as often as needed.

____ **I understand** any modifications or replacement of equipment must be approved by the Health Department prior to operation.

____ **I understand** floors, walls, ceilings in the float room must be maintained in a clean and sanitary condition as well as any shower, or toilet room shall be maintained according to 105 CMR 435.

____ **I understand** that water heaters, ventilation, electrical equipment, and lighting shall meet the requirements in 105 CMR 435.

____ **I understand** that adequate lighting must be provided to supply sufficient visibility when cleaning and when the patrons shower, enter, or exit the float tank.

____ **I have read and understand the Standard of Practice of the City of Northampton Board of Health.**

Signature _____ Date _____

Please Print Name _____ Title _____