Department of Health & Human Services
Board of Health
212 Main Street
Northampton, MA 01060
Tel: (413) 587-1214 ● Fax: (413) 587-1221
Commissioner: Merridith A. O'Leary, R.S.

FOR BOARD OF HEALTH USE ONLY
Date: _____
Amt Received: _____
Cash/Check No: _____
Received by: _____
Workers Comp Affidavit ☐
Bloodborne Pathogen ☐
CPR & First Aid ☐
Anatomy Course ☐
Photo ID ☐
Collector's Approval ☐

ALL FEES PAID ARE NON-REFUNDABLE

2026 BODY ART PRACTITIONER PERMIT APPLICATION

NO PERMITS WILL BE ISSUED IF TAXES ARE OWED

Name of Individual: _____ Home Telephone#: _____

Date of Birth: _____

Home Address: _____

Mailing Address (if different): _____

Body Art Establishment where Employed: _____

Body Art Establishment Owner (if different from applicant): _____

Body Art Establishment Telephone #: _____ Application Date: _____

Email Address: _____

NOTE:
A. INDIVIDUALS MUST PRACTICE IN A PERMITTED BODY ART ESTABLISHMENT.
B. IF THE INDIVIDUAL PERMIT HOLDER WILL BE PRACTICING BODY ART OUT OF HIS/HER ESTABLISHMENT, A SEPARATE ESTABLISHMENT APPLICATION MUST BE FILED AND A BODY ART ESTABLISHMENT PERMIT OBTAINED.

I declare the above facts are true and complete to the best of my knowledge and belief. I further understand that any false or misleading answer (s) will be cause for denial or revocation of my Permit to Practice Body Art.

Signature of Practitioner applying for Permit: _____

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.

If a guest artist, what dates will you be at establishment: _____

PLEASE MAKE ALL CHECKS PAYABLE TO THE CITY OF NORTHAMPTON

Type of Practice:	TATTOOING ☐	BODY PIERCING ☐	BOTH ☐	NEW APPLICANT ☐	RENEWAL ☐

Check Permit Type that Applies

√	Permit Type	Base Fee	Bloodborne Pathogen	CPR/First Aid	Anatomy Course	**TOTAL**
	Body Art Practitioner	$50.00				
	Temporary Body Art Practitioner	$50.00				
	Body Art Apprentice	$50.00				
	Body Art Probationary	$50.00				
Approved Trainer's Name Required for Apprentice or Probationary Permits **Name of Approved Trainer:**					TOTAL	

PRACTITIONERS:

1. Training-List on back, Blood Borne Pathogen training, current CPR & First Aid. Anatomy training for body piercing applicants. Please include copies of certificates and permits. Contacts/References.
2. Dates and Places of prior employment as a Body Arts Practitioner.
3. Present photo ID at the time of application.

TEMPORARY PRACTITIONERS:

1. Training-List on back, Blood Borne Pathogen training, current CPR, First Aid and evidence of 3 years continuous permitting. Anatomy training for body piercing applicants. Please include copies of certificates and permits. Contacts/References.
2. Present photo ID at the time of application.
3. Temporary Permits are issued for a 14 day period and will be limited to 4 per calendar year.

APPRENTICE:

1. Training-List on back, Blood Borne Pathogen training, current CPR, First Aid and evidence of 3 years continuous permitting. Anatomy training for body piercing applicants. Please include copies of certificates and permits.
2. Dates and Places of Apprentice or Probationary Practice.
3. Attach letter from approved trainer.
4. Present photo ID at the time of application.

PROBATIONARY:

1. Training-List on back, Blood Borne Pathogen training, current CPR, First Aid and evidence of 3 years continuous permitting. Anatomy training for body piercing applicants. Please include copies of certificates and permits.
2. Dates and Places of Apprentice or Probationary Practice.
3. Attach letter from approved trainer.
4. Present photo ID at the time of application.

BODY ART PRACTITIONER HISTORY & INFORMATIONAL PAGE

MUST BE FILLED OUT

1. **Training**: List all relevant courses taken:

   Name of Course: _____ Date: _____

   Institution: _____ Contact/Reference:_____ Phone: _____

   Name of Course: _____ Date: _____

   Institution: _____ Contact/Reference:_____ Phone: _____

   Name of Course: _____ Date: _____

   Institution: _____ Contact/Reference:_____ Phone: _____

   Name of Course: _____ Date: _____

   Institution: _____ Contact/Reference:_____ Phone: _____

2. **Experience**: List all prior Body Art Experience:

   Name of Establishment: _____ Address: _____

   Date(s) of Employment: _____ Reference: _____ Phone #: _____

   Name of Establishment: _____ Address: _____

   Date(s) of Employment: _____ Reference: _____ Phone #: _____

   Name of Establishment: _____ Address: _____

   Date(s) of Employment: _____ Reference: _____ Phone #: _____

   Name of Establishment: _____ Address: _____

   Date(s) of Employment: _____ Reference: _____ Phone #: _____

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
1 Congress Street, Suite 100
Boston, MA 02114-2017
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information **Please Print Legibly**

Business/Organization Name:_____

Address:_____

City/State/Zip:_____ Phone #:_____

Are you an employer? Check the appropriate box:

1. ☐ I am a employer with _____ employees (full and/ or part-time).*
2. ☐ I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
3. ☐ We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**
4. ☐ We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

Business Type (required):

5. ☐ Retail
6. ☐ Restaurant/Bar/Eating Establishment
7. ☐ Office and/or Sales (incl. real estate, auto, etc.)
8. ☐ Non-profit
9. ☐ Entertainment
10. ☐ Manufacturing
11. ☐ Health Care
12. ☐ Other _____

*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.
**If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.

Insurance Company Name:_____

Insurer's Address:_____

City/State/Zip: _____

Policy # or Self-ins. Lic. #_____ Expiration Date:_____

Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).

Failure to secure coverage as required under Section 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to $1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to $250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.

Signature:_____ Date:_____

Phone #:_____

Official use only. Do not write in this area, to be completed by city or town official.

City or Town: _____ Permit/License #_____

Issuing Authority (circle one):
1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office
6. Other _____

Contact Person:_____ Phone #:_____