

MACOMB COUNTY HEALTH DEPARTMENT  
ENVIRONMENTAL HEALTH SERVICES DIVISION  
43525 ELIZABETH RD.  
MT. CLEMENS, MI 48043

**BODY ART ESTABLISHMENT PLAN REVIEW APPLICATION**

Please provide all requested information along with appropriate plan review fee:

(2019) \$163.00 New Facility  
\$ 81.00 Remodel

**MAKE CHECKS PAYABLE TO: MACOMB COUNTY HEALTH DEPARTMENT OR MCHD  
ENVIRONMENTAL HEALTH SERVICES  
43525 ELIZABETH RD.  
MT. CLEMENS, MI 48043**

Incomplete applications will not be reviewed until missing information is provided. Do not leave fields blank, enter N/A if not applicable.

**Application Type:** New Facility   
Remodel Licensed Facility

**BUSINESS INFORMATION**

Business Name \_\_\_\_\_

Business Address \_\_\_\_\_  
Street City Zip

List All Body Art Procedures Performed \_\_\_\_\_  
\_\_\_\_\_

**OWNER INFORMATION**

Owner Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Owner Address \_\_\_\_\_  
Street City State Zip

Include Copy of Driver's License / I.D.

**FACILITY INFORMATION**

Provide floor plan drawn to scale (or dimensions provided) with all equipment, sinks and light fixtures included and identified. \_\_\_\_\_ (initial)

No. of technician work stations \_\_\_\_\_ Sq. ft. per station (min. 45 ft<sup>2</sup>) \_\_\_\_\_

Describe how technician work stations are separated from each other and from other areas of facility \_\_\_\_\_  
\_\_\_\_\_

Number of hand washing sinks (excluding sinks in restrooms) \_\_\_\_\_

Client waiting/retail area separated by panel/wall (min. 4 foot high) Yes  No

Separate instrument cleaning/sterilization area provided. Yes  No  N/A  (only single-use instruments)

Floor construction material \_\_\_\_\_

Wall construction material and finish \_\_\_\_\_

Ceiling construction material and finish \_\_\_\_\_

Floor and wall junctures sealed with cove molding. Yes  No

Exterior doors and restroom doors self-closing. Yes  No  Door finishes \_\_\_\_\_

Surface finishes: Counters \_\_\_\_\_

Tables \_\_\_\_\_

Procedure chairs/benches \_\_\_\_\_

Shelving \_\_\_\_\_

Cabinets \_\_\_\_\_

Other (specify) \_\_\_\_\_

\_\_\_\_\_

Windows and doors used for ventilation screened. Yes  No  N/A

**EQUIPMENT INFORMATION**

Reusable instruments used Yes  No

if Yes:

Number of instrument scrub sinks \_\_\_\_\_ Sink dimensions: width \_\_\_\_\_ length \_\_\_\_\_ depth \_\_\_\_\_

Number of ultrasonic cleaning units \_\_\_\_\_ Number of steam/pressure autoclaves \_\_\_\_\_

Number of dry heat autoclaves \_\_\_\_\_

Describe how sterilized instruments/equipment will be stored \_\_\_\_\_

How will tattoo/piercing machine(s) and connection(s) be cleaned and disinfected or covered \_\_\_\_\_

Waste containers with foot-pedal operated lids provided. Yes  No

Approved sharps containers provided. Yes  No

**WATER SUPPLY**

Municipal water supply? \_\_\_\_\_ or Approved onsite well? \_\_\_\_\_

All sink fixtures plumbed with hot and cold running water? Yes  No

**SEWAGE DISPOSAL**

Municipal sewage system? \_\_\_\_\_ or Approved on-site sewage system? \_\_\_\_\_

Janitorial/mop sink provided Yes  No

**GENERAL INFORMATION**

Copy of client notification form(s) provided for approval. \_\_\_\_\_(initial)

Copy of client aftercare instructions provided for approval. \_\_\_\_\_(initial)

Copy of client health assessment questionnaire provided for approval. \_\_\_\_\_(initial)

Copy of written Infection Control Procedures provided. \_\_\_\_\_(initial)

Copy of written Exposure Control Plan provided. \_\_\_\_\_(initial)

State and County Regulations Governing Body Art Establishments have been reviewed. \_\_\_\_\_(initial)

How will medical waste (sharps containers) be disposed? \_\_\_\_\_

All body art technicians have received Bloodborne pathogen, First Aid and CPR training? Yes  No   
If No, provide proof of registration in upcoming class.