

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:

(2021) \$166.00 New Facility
\$ 83.00 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 ft²) _____

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

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.

COPIES OF THE FOLLOWING FORMS MUST BE ATTACHED AND SUBMITTED FOR REVIEW:

Client notification form(s) _____(initial)

Client aftercare instructions _____(initial)

Client health assessment questionnaire _____(initial)

Infection Control Procedures _____(initial)

Exposure Control Plan _____(initial)