island health
Health Protection

APPLICATION FOR PERSONAL SERVICES FACILITY

COMPLETE ONE APPLICATION IN FULL FOR ***EACH PERSONAL SERVICE*** IN YOUR FACILITY
COMPLETED APPLICATIONS ARE TO BE SENT TO YOUR LOCAL HEALTH PROTECTION OFFICE ADDRESSES, EMAILS, AND CONTACT NUMBERS CAN BE FOUND AT: http://www.viha.ca/mho/contacts/hpes.htm

PLEASE PRINT WHERE POSSIBLE

STATUS

NEW ☐ New Facility ☐ New Location ☐ New Ownership **AMENDMENT** ☐ Change to Facility

PERSONAL SERVICES FACILITY

FACILITY NAME

FACILITY LOCATION ADDRESS

CITY POSTAL CODE

TELEPHONE FAX EMAIL

SEND INVOICE TO ☐ SAME AS FACILITY OR:

FACILITY'S REGISTERED ☐ OWNER(S) OR ☐ LEASEE(S)

REGISTERED **OWNER/LEASEE NAME**

MAILING ADDRESS

CITY PROV POSTAL CODE

TELEPHONE FAX EMAIL

ALTERNATE PHONE

☐ SOCIETY
☐ SOLE PROPRIETOR
☐ PARTNERSHIP
☐ INCORPORATED

FACILITY MANAGER / CONTACT

CONTACT NAME POSITION

ADDRESS POSTAL CODE

TELEPHONE FAX EMAIL

BUILDING INFORMATION

BUILDING NAME (IF DIFFERENT FROM FACILITY)

ADDRESS CITY POSTAL CODE

OWNER OF BUILDING OR COMPLEX

REGISTERED NAME

MAILING ADDRESS

CITY PROV POSTAL CODE

CONTACT/AGENT NAME POSITION

TELEPHONE FAX EMAIL

☐ SOCIETY
☐ SOLE PROPRIETOR
☐ PARTNERSHIP
☐ INCORPORATED

FACILITY SERVICING

WATER SOURCE ☐ COMMUNITY SYSTEM NAME ☐ WELL

SEWAGE DISPOSAL ☐ SEWER ☐ ONSITE SEWAGE DISPOSAL

OPERATIONAL MONTHS

NUMBER OF MONTHS OPEN OR OPERATING DURING YEAR (INCLUDE PARTIAL MONTHS) ☐**JAN** ☐**FEB** ☐**MAR** ☐**APR** ☐**MAY** ☐**JUN** ☐**JUL** ☐**AUG** ☐**SEP** ☐**OCT** ☐**NOV** ☐**DEC** ☐ ALL YEAR

FACILITY INFORMATION

☐ TATTOO/PERMANENT MAKEUP ☐ BODY PIERCING/MODIFICATION ☐ FLOTATION TANK ☐ TANNING ☐ OTHER (SPECIFY)

SINKS (#): STATION CHAIRS/TANKS/BEDS (#): TOTAL WORK AREA (SQ. FT.):

FLOOR FINISH: WALLS: TANK/TANNING BED MODEL:

LIGHTING TYPE: NUMBER OF FIXTURES:

INSTRUMENT STERILIZATION FACILITIES:

☐ ALLSINGLE USE PRE-STERILIZED ☐ STERILIZATION WITH AUTOCLAVE (SPECIFY TYPE):

SIZE OF CLEAN AREA AND STORAGE (SQ. FT.): VENTILATION:

SANITARY FACILITIES:

TOILETS(#): HAND SINKS(#):

FOOD/BEVERAGE SERVICES: ☐ YES ☐ NO

OPERATOR QUALIFICATIONS (SPECIFY):

VERIFICATION

☐ I have read the Guidelines for Personal Service Establishments

DATE DD / MMM / YYYY

APPLICANT SIGNATURE

I hereby certify that the information set out by me in this application is true and correct to the best of my knowledge and belief.
I acknowledge that it is an offence to supply false or inaccurate information on this application.

PROPOSED OPENING DATE

PRINT NAME POSITION

PHONE ADDRESS

FOR OFFICIAL USE ONLY					
	APPLICATION PACKAGE REC'D			FACILITY TYPE	
	FACILITY APPROVED BY E.H.O.			FACILITY #	
	POSTED TO HEALTHSPACE				