ARKANSAS DEPARTMENT OF HEALTH
BODY ART SECTION
4815 WEST MARKHAM, SLOT 8
LITTLE ROCK, AR 72205
(501) 682-2168

New Postsecondary Institution of Permanent and Semi-Permanent Cosmetics Application

INSTRUCTIONS

The Department of Health may grant licensure to an institution if the owner of the institution submits:

(1) The address and phone number of the institution

(2) Proof of accreditation within the previous six (6) months

(3) The floor plan of the institution to ensure adequate space for fundamental teaching and hands-on laboratory instruction

(4) The name, contact information, work experience, and license information for all sponsor educators teaching at the institution

(5) The background and resume of the owner

(6) Proof of registration and good standing with the Secretary of State under the name of the institution

(7) Proof of malpractice or liability insurance

(8) A detailed curriculum to be approved by the department

(9) A licensure fee of eight hundred fifty dollars ($850)

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INSTRUCTIONS: **File this application along with the $850.00 non-refundable fee to change the address of your location. Please see Rule No. 403-406 under the Department Rules for more information regarding opening a new institution /institution.**

INSTITUTION INFORMATION

INSTITUTION			TELEPHONE NUMBER	
MAILING ADDRESS	CITY	COUNTY	STATE	ZIP CODE
PHYSICAL ADDRESS	CITY	COUNTY	STATE	ZIP CODE
EMAIL ADDRESS (REQUIRED)	COURSES OFFERED PERMANENT COSMETICS SEMI-PERMANENT COSMETICS			

OWNER INFORMATION - If Sole Proprietorship or Partnership list the name, mailing address, and phone number for the owner(s).

OWNERSHIP INFORMATION	SOLE PROPRIETORSHIP PARTNERSHIP CORPORATION LLC			
OWNER NAME			TELEPHONE NUMBER	
MAILING ADDRESS	CITY	COUNTY	STATE	ZIP CODE
SOLE PROPRIETORSHIP OR PARTNERSHIP			TELEPHONE NUMBER	
MAILING ADDRESS	CITY	COUNTY	STATE	ZIP CODE

CORPORATION INFORMATION - If a Corporation, list the exact name of the Corporation, names, mailing address and phone number of the President, Secretary, and Agent of Service of the Corporation.

NAME OF CORPORATION			TELEPHONE NUMBER	
MAILING ADDRESS	CITY	COUNTY	STATE	ZIP CODE
PRESIDENT'S NAME and ADDRESS			TELEPHONE NUMBER	
SECRETARY'S NAME and ADDRESS			TELEPHONE NUMBER	
AGENT OF SERVICE NAME and ADDRESS			TELEPHONE NUMBER	

OWNER'S SIGNATURE	TODAY'S DATE

INSTITUTION SUPERVISOR FORM

1) Every institution shall at all times be in charge of and under the immediate supervision of the Institution Supervisor.
2) The Institution Supervisor must be currently licensed as an instructor.

SUPERVISOR'S NAME_____Phone #_____

EXPERIENCE RECORD: (Experience that qualifies for Supervisor Position)
EXPERIENCE (Employment date state Months and Years)

Employer's Name	Shop Name	City	State	Phone #	Emp Dates Beg/End
Employer's Name	Shop Name	City	State	Phone #	Emp Dates Beg/End
Employer's Name	Shop Name	City	State	Phone #	Emp Dates Beg/End

INSTRUCTOR EXPERIENCE (Employment date state Months and Years)

Employer's Name	Institution Name	City	State	Phone #	Emp Dates Beg/End
Employer's Name	Institution Name	City	State	Phone #	Emp Dates Beg/End
Employer's Name	Institution Name	City	State	Phone #	Emp Dates Beg/End

CERTIFICATION

I, _____, do hereby certify that the employment record contained on this form is an accurate record of my employment history.

DATE: _____SUPERVISOR'S SIGNATURE_____

I, _____, d/b/a _____ do hereby certify that the above-named individual is under my employment in the capacity of INSTITUTION SUPERVISOR.

DATE:_____ OWNER'S SIGNATURE_____

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BODY ART SECTION

AUTHORIZED DESIGNEE CERTIFICATION

I, _____, d/b/a _____
OWNER'S NAME INSTITUTION NAME

do hereby designate and authorize _____ to accept service of notice
DESIGNEE'S NAME
from the Department and to transact all business negotiations on behalf of the institution , including answers to citations for

hearing, and compliance with rulings issued by the Department.

DATED THIS _____DAY OF _____, 20____.

_____
OWNER/ADMINISTRATOR'S SIGNATURE

_____
DESIGNEE'S SIGNATURE

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NAME OF INSTITUTION :_____

ADDRESS OF INSTITUTION :_____

INSTITUTION SCHEDULE

HOURS OF OPERATION

M _____
T _____
W _____
T _____
F _____
S _____

THEORY CLASS SCHEDULE

M _____
T _____
W _____
T _____
F _____
S _____

I ALSO HAVE IN MY INSTITUTION A TIME CLOCK FOR KEEPING ACCURATE TIME RECORDS FOR STUDENTS (yes) _____ (no) _____. IF ANSWER IS NO, PLEASE EXPLAIN: _____

_____ _____
Signature of Owner and/or Instructor Date