WEST HARTFORD-BLOOMFIELD HEALTH DISTRICT
580 Cottage Grove Road, Suite 100, Bloomfield, CT 06002
Phone: (860) 561-7900 Fax: (860) 561-7918

FOR OFFICE USE ONLY

Fee Paid $_____

Check/CC #: _____

Cash/M.O: _____

Receipt #: _____

2025-2026 APPLICATION FOR SALON LICENSE

All SECTIONS MUST BE FILLED IN *(please type or print clearly)*

A fee of **$200.00** must accompany this application

Name of Establishment: _____

Email_____

Address: _____ Bus. Phone_____
Street

_____
Town State Zip Code

Mailing/Billing Address *(if different)*:_____
Street

_____
Town State Zip Code

Name of Operator: _____

Operator Phone: _____ Operator E-Mail Address_____

Name of Owner *(if different from operator*): _____

Owner's Home Address: _____ Phone: _____
Street

_____
Town State Zip Code

Owner's Email Address: _____

SERVICES PROVIDED *(please check all that apply)*

_____ Barbering _____Tanning _____Eyelash Extensions

_____ Hairdressing _____ Tattoo _____ Esthetics

_____ Cosmetology _____Body Piercing

_____ Nail _____ Other: _____

Hours of Operation	
Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

ON THE BACK OF THIS FORM, PLEASE LIST THE NAMES & LICENSE NUMBERS OF ALL LICENSED PERSONNEL & PROVIDE COPIES OF ALL APPLICABLE CT STATE LICENSES.

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The undersigned agrees to comply with any and all ordinances and regulations of the towns of West Hartford and Bloomfield and The State of Connecticut. The WHBHD must be notified of any changes in ownership, location or renovation.
Permits are not transferable between salon owners and locations.

SIGNATURE OF OWNER **DATE**

PLEASE PRINT NAME, CLEARLY ***(Please turn page over for additional information)***

WEST HARTFORD-BLOOMFIELD HEALTH DISTRICT

Licensed Personnel	License Number(s)