

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 #:	_____

2026-2027 APPLICATION FOR SALON LICENSE

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

A fee of \$250.00 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)

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Barbering | <input type="checkbox"/> Tanning | <input type="checkbox"/> Eyelash Extensions |
| <input type="checkbox"/> Hairdressing | <input type="checkbox"/> Tattoo | <input type="checkbox"/> Esthetics |
| <input type="checkbox"/> Cosmetology | <input type="checkbox"/> Body Piercing | |
| <input type="checkbox"/> Nail | <input type="checkbox"/> 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.

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)

