

TOWN OF SHARON -- BOARD OF HEALTH  
90 SOUTH MAIN ST., SHARON MA 02067  
781-784-1510 (FAX: 781-784-1509)

THIS APPLICATION MUST BE COMPLETED IN FULL--OR APPLICATION WILL NOT BE PROCESSED.

**PERMIT TO OPERATE A MANICURING SALON PROVIDING ARTIFICIAL NAIL SERVICES**

**APPLICATION FOR LICENSE RENEWAL**

ALL PERTINENT PROVISIONS OF 240 CMR 3.00 - 7.00 MUST BE MET BEFORE A PERMIT WILL BE ISSUED.

DATE OF APPLICATION: \_\_\_\_\_

NAME OF ESTABLISHMENT: \_\_\_\_\_ TEL: \_\_\_\_\_

ADDRESS OF ESTABLISHMENT: \_\_\_\_\_

TYPE OF BUSINESS (Choose One):

- MANICURE SALON ONLY - PROVIDING ARTIFICIAL NAIL SERVICES  
 BEAUTY SALON WITH ARTIFICIAL NAIL SERVICES PROVIDED

NAME OF OWNER: \_\_\_\_\_ HOME TEL# \_\_\_\_\_

ADDRESS OF OWNER: \_\_\_\_\_  
Street city/town state zip code

NAME OF MANAGER, IF DIFFERENT THAN ABOVE: \_\_\_\_\_

IF OWNERSHIP IS A PARTNERSHIP OR CORPORATION, PLEASE LIST NAME AND ADDRESS OF PARTNERS OR CORPORATE OFFICERS(Use reverse side of application if additional space is needed.)

NAME: ADDRESS: ZIP CODE: TEL#

PURSUANT TO M.G.L. CHAPTER 62C, SECTION 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY, THAT I TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW.

\_\_\_\_\_  
SOCIAL SECURITY NO.  
OR FEDERAL I.D. NO.

\_\_\_\_\_  
SIGNATURE OF APPLICANT/CORPORATE NAME

BY:

\_\_\_\_\_  
CORPORATE OFFICER (IF APPLICABLE)

LIST NAMES AND LICENSE NUMBER (ISSUED BY MASSACHUSETTS BOARD OF REGISTRATION OF COSMETOLOGISTS)  
OF ALL CURRENTLY EMPLOYED MANICURE PRACTITIONERS (NAIL TECHNICIANS)

\_\_\_\_\_  
NAME LICENSE # (ISSUED BY MA BOARD OF REGISTRATION OF COSMETOLOGISTS)

IF ADDITIONAL SPACES ARE NEEDED, PLEASE USE REVERSE SIDE OF APPLICATION.

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