



CHESPROCOTT HEALTH DISTRICT

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www.chesprocott.org

Maura A. Esposito RS, MPH, Director of Health

Barbershops, Hairdressers, Cosmetology, Nail Salons Plan Review Application

Please fill out this form completely. The following items must be submitted with the application to be a complete submission:

- One (1) copy of the floor plan drawn to scale. This floorplan must include locations of stations, hair sinks, handsinks, utility sinks and chemical mixing sinks. The plan should also include finish schedule for floors.
- A complete set of equipment specifications, numbered on the specification sheets to correspond with numbered on the plan. The equipment model numbers must be identified on the specification sheets.
- A copy of each State issued license as well as a copy of that individual's driver's license.
- A list of all services provided.

Our office has **7 to 10 business days** to review and respond.

A \$225 review fee must be submitted with application.

Name of Establishment _____ Phone _____

Address _____ Town, State, Zip _____

Owner of Establishment _____ Phone _____

Address _____ Town, State, Zip _____

Name of Applicant _____ Phone _____

Address _____ Town, State, Zip _____

Applicant Title (owner, architect, manager, etc.) _____

New Establishment Conversion Remodel of Existing Establishment Change of Owner

Projected Start Date: _____ Projected Completion Date: _____

Type of Business

Barbershop Nail Salon Hairdressing/Cosmetology Cosmetology Salon

Sewage Disposal

- Public Sewer
 Septic System

Water Supply

- Public Water
 Private Well

of Chairs _____ # of Stations _____ # of Hair Sinks _____ # of Bathrooms _____

Square Footage of Facility _____ Estimated Daily Water Usage (septic only) _____

Hours of Operation Monday _____ Tuesday _____ Wednesday _____
Thursday _____ Friday _____ Saturday _____ Sunday _____

Food and Drink

To be provided? (Specify) _____

In-Residence Shop

Separated from living space (Specify) _____

Sanitizer/Disinfection

Type _____ EPA Registration Number _____

Concentration _____

Laundry

In house (Washer AND Dryer required.): _____ Sanitizer used: _____

Professional Laundry Service (Provide contract) : _____

Ventilation (Nail Salons)

Type: _____ Location(s): _____

Additional Notes:

In office only:

Revisions Needed: _____

Plan Approved: _____ Date _____ By: _____