



## West New York Health Department

428 – 60<sup>th</sup> Street, Room 30

West New York, N.J. 07093

(201) 295-5070 Fax (201) 295-0769

**Gabriel Rodriguez**  
Commissioner of Revenue & Finance

**Janet Castro**  
Health Officer

**Maria Alvarez**  
Registrar of Vital Statistics

### APPLICATION FOR BARBER SHOP, BEAUTY SALON & NAIL SALON

Your Current License Expires JAN 1<sup>st</sup> Of Every Fiscal Year

Date: \_\_\_\_\_

Trade Name: \_\_\_\_\_

Trade Address: \_\_\_\_\_

Owner's Name: \_\_\_\_\_

Proprietor State License #: \_\_\_\_\_ Tel #: \_\_\_\_\_

Applicant's Name: \_\_\_\_\_ Tel #: \_\_\_\_\_

Applicant's Address: \_\_\_\_\_

Number of Chairs: \_\_\_\_\_ Number of Employees: \_\_\_\_\_

Name of Employees and State License Number:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby state and affirm that all the facts stated herein by me are true. I also understand and acknowledge that it is unlawful for me or any employees to operate while suffering from any venereal disease tuberculosis, or any other infectious or communicable disease.

#### **PLEASE SEND COPIES OF ALL YOUR LICENSES**

SHOP STATE LICENSE, BARBER LICENSE, HAIR STYLIST LICENSE, MANICURE LICENSE, BUSINESS

#### **MUST SEND COPY OF CERTIFICATE OF OCCUPANCY**

Fee: \$75.00

Only Money Orders Will Be Accepted

Payable To: West New York Health Department

Date Received: \_\_\_\_\_

Received By: \_\_\_\_\_

Money Order #: \_\_\_\_\_