ASHFORD
BOROUGH COUNCIL

Local Government (Miscellaneous Provisions) Act 1982 (as amended)

Application for Registration to Carry on the Practice of Skin Piercing

I/we hereby make application under the provisions of the above Act for registration to carry on the following practices (tick all that apply) at the premises detailed below:

Acupuncture ☐
Tattooing to include Semi Permanent Skin ☐ **Colouring**
Semi-permanent skin-colouring ☐
Ear Piercing ☐
Cosmetic Piercing ☐
Electrolysis ☐
Other skin piercing treatments, Please specify _____ ☐

Please note: we currently do not register aesthetic treatments such as Botox, dermal fillers, dermal implants, vitamin injections, laser treatments or tattoo removal.

Part 1: Applicant / Business / Premises / Contact details	
Name(s) of applicant(s) in full	
Trading name of business	
Address of premises to be registered	
Contact details for the **applicant:**	Telephone: Mobile: Email:
Contact details for **business:** (if different to above)	Telephone: Mobile: Email:
Website address (if applicable)	

Part 2: Documentation / Facilities / Operation	
Full details of treatments provided Please list all treatments you will be providing including those that do not require registration.	
Documentation (Health and Safety at Work etc. Act 1974) Provide copies of the following: • Client consent form • Confirmation of age (under 18's) • Patient records and treatments • Infection control procedure • Procedure for dealing with blood spillages and / or unintentional contact with equipment to include inks	
Type of premises Please describe where your business will be operating from, for example: • Room(s) within your domestic setting • Separate room/studio at your home address but separate from main house • Either of the above but you do not own the domestic residence. • Business address not linked to home (including 'High Street' location • Mobile unit	
How many treatment rooms will you be using: • If more than one, please state what each room will be used for. • Provide details of WC facilities and hand washing facilities as appropriate.	

Is there a **WC** available? Please state if: • For staff use only • For staff and client use • Separate facilities for staff and clients	
What **hand washing facilities** are available? Please detail: • How many WHB and where they are sited • If there is separate hot and cold water or single mixer tap. (If mixer tap what temperature is the water set at) • What type of soap and towels are provided? • Is the water supply mains? If no, please provide details • Does the waste connect to mains drainage? If no, please provide details	
Cleaning premises and fixtures Please detail the main items of furniture and fittings in the treatment room to include treatment couch/chair etc. Describe how you will keep the premises and fixtures clean including how when you clean and what cleaning agents are used.	
Equipment Please detail equipment you intend to use for relevant treatments. Include details of grips where used. Please attach photograph	
Needles **Are you using disposable or re-usable needles?**	
Sterilizing equipment Please identify any pieces of equipment you will sterilise and how this will be done. Provide details of sterilising equipment (autoclave / ultrasonic etc.). Detail times and temperatures.	

Provide details of how you are disposing of sharps Provide name and address of contractor.	
Provide details of how you are disposing of all other clinical waste (including used wipes / aprons / gloves / ink pots etc.)? Provide name and address of contractor.	
Waste disposal (non-clinical) How will you dispose of non-clinical waste (general waste)	
Cross contamination / cross infection Please describe practices you have in place to reduce the risk to staff and client(s) of cross contamination / cross infection in the event of: • Unintentional blood contamination (practitioner / client) • Contamination of equipment and or surfaces • Incorrect waste separation Include use of sterilising solutions, wipes, hand washing etc.	
Have you ever been convicted of any offence under the Local Government (Miscellaneous Provisions) Act 1982 or Health & Safety at Work etc. Act for offences related to this application? If so, please provide details.	
Signature of Applicant	
Date of signature	

PAYMENT OF FEE	
Please confirm the appropriate fee prior to submission of the application form. Where possible payment to be made electronically.	
For office use	
Amount due:	**Paid : Yes/No**

Part 3: Practitioner (s) details

Please complete details for EACH practitioner in your skin piercing operation.

FIRST PRACTITIONER

Full name:

Home address:

Activities to be undertaken (please tick all that apply)

Acupuncture ☐
Tattooing ☐
Semi-permanent skin-colouring ☐
Ear Piercing ☐
Cosmetic Piercing ☐
Electrolysis ☐
Microblading / micropigmentation / tricopigmentation ☐
Other skin piercing treatments, Please specify _____ ☐

Training: Provide details of all relevant qualifications and training giving dates and course title / details: Please provide copies of all qualifications and relevant training with your application.

Experience: Detail number of years' experience in the treatment you are applying for.

Include dates and location:

Where you have practiced: Provide details of other District (s) where you have previously been registered for the treatments being applied for.

District	Treatment	Dates

Have you been refused registration, or otherwise required to cease delivering treatments in any other District? **Y/N**

Please provide details including the District concerned.

Have you ever been convicted of any offence under the Local Government (Miscellaneous Provisions) Act 1982 or Health & Safety at Work etc. Act, for offences related to this application?

If so, please provide details. No

Signature of practitioner: _____

Date: _____

SECOND PRACTITIONER

Full name:

Home address:

Activities to be undertaken (please tick all that apply)

Acupuncture ☐
Tattooing ☐
Semi-permanent skin-colouring ☐
Ear Piercing ☐
Cosmetic Piercing ☐
Electrolysis ☐
Microblading / micropigmentation / tricopigmentation ☐

Other skin piercing treatments, Please specify _____ ☐

Training: Provide details of all relevant qualifications and training giving dates and course title / details: Please provide copies of all qualifications and relevant training with your application.

Experience: Detail number of years' experience in the treatment you are applying for.

Include dates and location:

Where you have practiced: Provide details of other District (s) where you have previously been registered for the treatments being applied for.

District	Treatment	Dates

Have you been refused registration, or otherwise required to cease delivering treatments in any other District? Y/N

Please provide details including the District concerned.

Have you ever been convicted of any offence under the Local Government (Miscellaneous Provisions) Act 1982 or Health & Safety at Work etc. Act, for offences related to this application?

If so, please provide details. No

Signature of practitioner: _____

Date: _____

THIRD PRACTITIONER

Full name:

Home address:

Activities to be undertaken (please tick all that apply)

Acupuncture ☐
Tattooing ☐
Semi-permanent skin-colouring ☐
Ear Piercing ☐
Cosmetic Piercing ☐
Electrolysis ☐
Microblading / micropigmentation / tricopigmentation ☐

Other skin piercing treatments, Please specify _____ ☐

Training: Provide details of all relevant qualifications and training giving dates and course title / details: Please provide copies of all qualifications and relevant training with your application.

Experience: Detail number of years' experience in the treatment you are applying for.

Include dates and location:

Where you have practiced: Provide details of other District (s) where you have previously been registered for the treatments being applied for.

District	Treatment	Dates

Have you been refused registration, or otherwise required to cease delivering treatments in any other District? Y/N

Please provide details including the District concerned.

Have you ever been convicted of any offence under the Local Government (Miscellaneous Provisions) Act 1982 or Health & Safety at Work etc. Act, for offences related to this application?

If so, please provide details. No

Signature of practitioner: _____

Date: _____

Ashford Borough Council is the data controller for any personal information collected in this application. Your information will be used to administrate the licence, processing is being conducted relying upon a contractual legal basis. Your data may be shared with other departments within the council for the purpose of improving services, keeping records up-to-date and for the protection of the public fund. It may also share your data with other bodies responsible for auditing public funds for these purposes. You can find further information about data sharing to identify fraud at ashford.gov.uk/transparency/information-rights/privacy/counter-fraud-privacy-notice. Your information will be retained as long as you hold the licence + 12 years. For more information about your data protection rights please see our data protection pages which can be found at ashford.gov.uk/transparency/information-rights or contact the Data Protection Officer, Ashford Borough Council, International House, Dover Place, Ashford, Kent, TN23 1HU.

Return to Licensing, Ashford Borough Council, International House, Dover Place, Ashford, Kent, TN23 1HU or email: licensing@ashford.gov.uk

Please provide copies of all qualifications and relevant training with your application.