Body Art Temporary Individual App

Environmental Health Division

Wichita Falls-Wichita County Public Health District

1700 Third St. | Wichita Falls, TX 76301 | 940-761-7800 | www.health.wichitafallstx.gov

Site No._____

Date Received_____

For Office Use Only

Incomplete Applications will not be approved

Must include proof of Blood Borne Pathogens Training and either proof of Hepatitis B Vaccination or submit a Refusal to Vaccinate Form.
Temporary Licenses last no more than 7 consecutive days and applicants are limited to 4 Temporary Licenses per year per jurisdiction.

Name: _____Date of Birth: _____
First Middle Last MM/DD/YEAR

Home Address:_____City/State/Zip:_____

Mailing Address:_____City/State/Zip:_____

Best Daytime Phone: (_____)_____Secondary Phone: (_____)_____

E-Mail Address: _____

Business Name:_____ Business Phone: (_____)_____

Business Address: _____City/State/Zip:_____

Emergency Contact Person:_____ Phone: (_____)_____

Temporary License Type: ☐ Tattoo or Cosmetic ONLY ☐ Piercing ONLY ☐ Tattoo or Cosmetic AND Piercing

2 YEAR WORK HISTORY (or provide State License)		
Start Date:	End Date:	Establishment Name:
Establishment Phone:		Establishment Address:
Start Date:	End Date:	Establishment Name:
Establishment Phone:		Establishment Address:
Start Date:	End Date:	Establishment Name:
Establishment Phone:		Establishment Address:
Start Date:	End Date:	Establishment Name:
Establishment Phone:		Establishment Address:
Start Date:	End Date:	Establishment Name:
Establishment Phone:		Establishment Address:

FEES
$50 Temporary Individual Body Art License

TOTAL LICENSE FEES DUE
$50

I apply for a temporary license to conduct Body Art in a permitted Body Art Establishment and by this application do agree to comply with the rules and regulations set forth by the Wichita Falls-Wichita County Public Health District. I (we) understand that any falsifications or omissions as to the material fact or any violation of any law by designees or myself will constitute grounds for revocation or suspension of this permit by the Health District.

Applicant Print Name _____ Applicant Signature _____ Date _____