

PLEASE CHECK ONE OF THE FOLLOWING:

- ☐ BASIC REGISTRATION ☐ NEW OWNER ☐ NEW CONSTRUCTION ☐ EXTENSIVE REMODELLING

(If new operation, please specify opening date) _____

NAME OF BUSINESS: _____

STREET ADDRESS: _____ CITY: _____ POSTAL CODE: _____

TELEPHONE: (____) _____ FAX: (____) _____ EMAIL: _____

MAILING ADDRESS FOR BUSINESS:

- ☐ SAME AS ABOVE ☐ ALTERNATE MAILING ADDRESS (i.e. P.O.Box): _____

CITY _____ PROVINCE: _____ POSTAL CODE: _____

LEGAL OWNER OF BUSINESS: (Owner or Company Applying for Permit)

- ☐ Company Name _____

- ☐ Partnership _____

- ☐ Sole Proprietorship _____

Company Contact Person: _____ Driver's License # _____

STREET ADDRESS: _____

CITY: _____ PROVINCE: _____ POSTAL CODE: _____

TELEPHONE: (____) _____ CELL: (____) _____ EMAIL: _____

ON SITE CONTACT PERSON: _____

BODY MODIFICATION CERTIFICATE: ☐ YES ☐ NO Required by City of Wpg By-law No.40/2005 for each body modification technician practicing body modification in the City of Winnipeg.

PLAN SUBMITTED: (Required for new construction or extensive remodelling). ☐ YES ☐ NO

A detailed drawing showing workstations, cleaning & sterilizing room, storage, service areas, washrooms, staff rooms, equipment layout, and a listing of equipment and construction materials in workstations and cleaning & sterilization room to be provided.

STERILIZATION METHOD:

- ☐ Autoclave ☐ Single use only ☐ Chemical (indicate type) _____

DATE

SIGNATURE OF OWNER/REPRESENTATIVE

For Office Use Only: (CHECK APPROPRIATE BOX)

Body Modification:(permit required-Wpg only)

<input type="checkbox"/> Tattoo	<input type="checkbox"/> Piercing	<input type="checkbox"/> Permanent Makeup	<input type="checkbox"/> Dermal Anchors	<input type="checkbox"/>
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Esthetics:

<input type="checkbox"/> Nails	<input type="checkbox"/> Skin Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Hair Removal:

<input type="checkbox"/> Electrolysis	<input type="checkbox"/> Laser	<input type="checkbox"/> Sugar/Waxing	<input type="checkbox"/> Threading	<input type="checkbox"/>
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Other:

<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Colonic Irrigation	<input type="checkbox"/> Floatation Tank	<input type="checkbox"/> Barbering	<input type="checkbox"/> Hair Styling	<input type="checkbox"/>
<input type="checkbox"/> Mud Bath	<input type="checkbox"/> Spas (health/fitness clubs)	<input type="checkbox"/> Steam bath	<input type="checkbox"/> Tanning	<input type="checkbox"/> Massage/Therapeutic Touch	<input type="checkbox"/> Other: _____

PLEASE RETURN THE REGISTRATION FORM TO

healthprotection@gov.mb.ca