



Salon Plan Review Application Form

Establishment _____

Address _____

City, State, Zip _____

Phone _____

Owner _____

Owner Address _____

Owner City, State, Zip _____

Operator _____ Original Date of License _____

Operator Address _____

Operator City, State, Zip _____

Number of Stations _____

of hairdressers or technicians _____

Services Provided: Barbering
 Manicures

Hairdressing
 Pedicures

Licensed Cosmetologists

Name

License #

_____	_____
_____	_____
_____	_____
_____	_____

Please mail checks only payable to: Central Connecticut Health District, 2080 Silas Deane Highway, Rocky Hill, CT 06067

Office Use Only	Received _____	Check # _____	Entered _____
Plan Review Fee: (100% of Annual Fee) 1-4 Stations, \$105.00 5-9 Stations \$140.00, 10+ Stations \$170.00			