



### TATTOO PARLOR PERMIT APPLICATION FORM

Community Development Department-Health Inspection Division  
111 E Maple St  
P. O. Box 1019  
Independence, MO 64051-0519  
Phone: (816) 325-7803 Fax: (816) 325-7770  
www.independencemo.org

This form must be completed for all new and change of ownership facilities and for any changes to facility information. **If the information on this application changes, this department is to be notified. Picture identification is required to process application (i.e. driver's license, passport, etc.)** PLEASE PRINT LEGIBLY.

Facility Name: (as it will be shown on permit)	Phone: ( ) _____
Facility Address:	Fax: ( ) _____
	Cell: ( ) _____
	Email: _____
	Website: _____

Anticipated Opening Date: _____	Ownership Legal Type: <input type="checkbox"/> LLC <input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership	Date of Location: _____
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#### OWNERSHIP INFORMATION

Owner's Name: _____	Previous Tattoo License# _____	Phone: ( ) _____
Owner's Address: _____ City, State: _____ Zip: _____	Date of Birth: _____	Cell: ( ) _____
	SS#: _____	Fax: ( ) _____
	DL #: _____	Email: _____
		Website: _____

#### CO-OWNER/PARTNER INFORMATION

Owner's Name: _____	Previous Tattoo License# _____	Phone: ( ) _____
Owner's Address: _____ City, State: _____ Zip: _____	Date of Birth: _____	Cell: ( ) _____
	SS#: _____	Fax: ( ) _____
	DL #: _____	Email: _____

#### EMPLOYEE INFORMATION

Names of managing officers, employees:

Name	Address	Date of Birth

A HEALTH CERTIFICATE ISSUED BY A LICENSED MEDICAL PRACTITIONER IS REQUIRED FOR EACH EMPLOYEE LISTED (use back of form if needed)

For Office use only: Date: \_\_\_\_\_  Approved  Not Approved Permit# \_\_\_\_\_

Signature \_\_\_\_\_

Title \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_