

DEPARTMENT OF HEALTH – DIVISION OF LICENSING



APPLICATION FOR HAIR SALON / BARBER SHOP – UNION CITY, NEW JERSEY

CATEGORY: _____ ADDRESS OF BUSINESS _____

TELEPHONE # _____ TRADE NAME OF BUSINESS _____

IS OWNERSHIP A CORPORATION/PARTNERSHIP (GIVE NAME) _____

PRINCIPAL AGENT (NAME/ADDRESS AND PHONE # _____

OWNER: _____ TELEPHONE NUMBER _____

ADDRESS: _____ BIRTHDATE: _____

OWNER BIRTHPLACE: _____ CITIZENSHIP _____

SOCIAL SECURITY #: _____ DRIVER LICENSE #: _____

IF OWNER LIVED AT ABOVE ADDRESS LESS THAN 3 YEARS GIVE PREVIOUS ADDRESS: _____

HAS THE APPLICANT EVER BEEN CONVICTED FOR A CRIME OR MISDEMEANOR (YES/NO): _____

IF SO, PLEASE LIST THE NATURE OF THE OFFENSE FOR WHICH ARRESTED & CONVICTED: _____

NAME AND LOCATION OF CARTING COMPANY: _____

FORM MUST BE NOTARIZED

APPLICANT SIGNATURE: _____

SWORN & SUBSCRIBED BEFORE ME THIS _____ DAY OF _____

I certify that that the statements made herein are accurate, true & correct. I understand that any false information given on this form will lead to termination of this application and any license issued. This application is made for the owner who will be able to receive a license from the Union City Department of Health and who agrees to comply with all the ordinances of the Health Department, City of Union City for license registration.