



**Public Health**  
Prevent. Promote. Protect.

Hendricks County Health Department

## Temporary Tattoo, Piercing and Body Modification Application

Send completed application with payment to:

Hendricks County Health Department  
355 South Washington St. G30, Danville, IN 46122  
Phone (317) 745-9217 • Fax (317) 745-9218

### Booth/Station Information

Name and Date(s) of Event: \_\_\_\_\_

Booth Name: \_\_\_\_\_

Number of Artist in Booth: \_\_\_\_\_ x \$50.00 = \_\_\_\_\_ Fee enclosed

List dates and hours of Booth operation: \_\_\_\_\_

\_\_\_\_\_

### Booth Owner/Operator Information

Owner/Operator Name: \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Please attach current spore test result and aftercare instructions that will be handed out to your patrons. In addition, the day of show you must have a copy of your latest spore test result to be given to Health Department staff prior to opening the booth.

***\*Please note Body Modification permits are non-transferable.*** Permit issued applies only to the above booth/station, and to the listed temporary event.

***I, the undersigned, affirm that the foregoing information and representations are true, and I understand that any booth operator and artist will be immediately removed from the premises if the Health Department determines that they do not meet State and local requirements of 410 IAC 1-5, IC 35-42-2-7 and Hendricks County Health Department Ordinance 2010-09.***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Booth Owner/Operator)

For office use only: Receipt # \_\_\_\_\_ Receipt Amount \$ \_\_\_\_\_ Date Payment Received: \_\_\_\_\_

**Information Required For All Working Artists**

**Artist Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Mobile Phone:** \_\_\_\_\_

**Driver's License or Photo ID**

**Photograph of Artist**

**Current Bloodborne Pathogen Training Certificate**

**Hepatitis B Vaccination Record or Hepatitis B Vaccination Declination Statement**

**Artist Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Mobile Phone:** \_\_\_\_\_

**Driver's License or Photo ID**

**Photograph of Artist**

**Current Bloodborne Pathogen Training Certificate**

**Hepatitis B Vaccination Record or Hepatitis B Vaccination Declination Statement**

**Artist Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Mobile Phone:** \_\_\_\_\_

**Driver's License or Photo ID**

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