



The Public Health Act
APPLICATION FOR HEALTH CERTIFICATE FOR BEAUTY THERAPIST,
COSMETOLOGIST/BARBERS AND HAIRDRESSERS

Name: _____

Address: _____

D.O.B: _____ Sex: _____

Telephone #: _____

Occupation: _____

Name of Employee: _____

Business Address of Employer: _____

Have you ever applied for Health Certification? Yes No

Was application granted or refused: Yes No

If refused, state reason: _____

Number on most recent Licence Reg. # _____ Lic.# _____

Date: _____ Signature: _____

FOR OFFICE USE ONLY

Amount of Fee Paid: _____ Receipt Number: _____

Date of Examination: _____ Permit granted/refused: Yes No

Reason for Refusal: _____

Permit Number: _____

Date: _____

Signature of Medical Officer (Health) _____