

**RHODE ISLAND DEPARTMENT OF HEALTH
DIVISION OF OCCUPATIONAL AND RADIOLOGICAL HEALTH
APPLICATION FOR REGISTRATION TANNING EQUIPMENT**

FOR AGENCY USE ONLY

Lic. No. TAN

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Reviewed By _____

Date _____

Amount Paid _____

INSTRUCTIONS: Send the entire completed application and fee to: RI Department of Health, Office of Facilities Regulation, 3 Capitol Hill - Room 305, Providence, RI 02908-5097. Application Fee (\$230.00) made payable to RI General Treasurer. You should keep a copy of your completed application and attachments, as they will be incorporated into your registration by reference. This Agency is requesting that you provide information that is necessary to accomplish the statutory purpose as outlined under Public Act R-23-68-TAN. Disclosure of this information is mandatory. You can contact the Office of Facilities Regulation at (401) 222-2566 with any questions regarding this application.

Type of Application: New Facility Change of Location (Tentative Date of Opening) _____

Change of Ownership (Date of Ownership Change) _____ Previous Owner-Registration No: TAN

**Primary Operation of Facility
(Choose One)**

- Tanning Facility Health Club Beauty Salon/Barber Shop Hotel/Motel
 Gym Other _____

Facility Name:

Please provide the name of the facility (as known to the public) for which you are applying for this license.

Name: _____

Facility Contact Person:

Please provide the name and telephone number of a person we can contact concerning this facility.

Name: _____

Phone Number: (____) _____

Facility Mailing Information:

Please provide the mailing information for all communication regarding this license.

(Not published on HEALTH website).

Address Line 1 _____

Address Line 2 _____

Address Line 3 _____

Address City, State, Zip Code _____

Address Country _____

Phone: _____ Fax: _____ Email Address: _____

Facility Location Information:

Please provide the location information for this facility.

(Published on HEALTH website).

Address Line 1 _____

Address Line 2 _____

Address Line 3 _____

Address City, State, Zip Code _____

Address Country _____

Phone: _____ Fax: _____ Email Address: _____

Ownership Type:

Please check ONE

- Corporation Limited Liability Company Governmental Entity Partner
 Sole Proprietorship Partnership Limited Partnership

Ownership Information: Please provide ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.	Name: _____ DBA: _____
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Name and Policy or Binder Number of Liability Insurance Company:

Name: _____

Policy Number: _____

Tanning Equipment Information: Please identify room(s) which tanning equipment occupies. Provide model and serial numbers for all devices of tanning facility if applicable. Types of equipment include bed canopy, bed bench, stand-up booth, free-standing facial unit, and free-standing canopy. (Note: Bed canopy and bed bench may have separate model numbers.)

Room Number	Manufacturer	Model Number(s)	Month & Year of Manufacture	Type of Equipment

Continue on plain 8½" by 11" paper if necessary

Days and Hours of Operation:

Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____

Saturday _____ Sunday _____

FEIN Number: (Federal Employer Identification Number) Note: If you are a sole proprietor this number may be your Social Security Number.	Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator. Please provide below FEIN/SSN for this license: F.E.I.N./SSN Number: _____
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CERTIFICATION [*Must be completed by the owner if an individual, by one of the partners if a partnership; by an officer of the corporation if incorporated*]:

I, _____ affirm that I am the _____

full name title

of the _____, that I am authorized on the part of said applicant to

facility name as shown on page 1

verify and file with the Rhode Island Department of Health, this application; that I have full knowledge of the matters set forth herein and that all of the same are true in substance and fact.

(Signature) Date

Printed Name and Title