



**TATTOO & BODY PIERCING ESTABLISHMENT VARIANCE
OR HEALTH DEPARTMENT APPROVAL APPLICATION
FOR SPECIALIZED PROCESSES, PRACTICES OR CONDITIONS**

OFFICE OF THE CITY CLERK, LICENSE DIVISION
CITY HALL, 200 E. WELLS ST, ROOM 105, MILWAUKEE, WI 53202
(414) 286-2238 ▪ license@milwaukee.gov ▪ www.milwaukee.gov/license

No Fee: If submitting with your initial Tattoo & Body Piercing Application.
\$75 Fee: If you are an existing establishment and submitting this form with a Modification Request.

| APPLICANT | |
|--------------------|-------------------------|
| Legal Entity Name: | Trade/DBA Name: |
| Business Address: | Business Phone #: |
| Agent's Name: | Agent's Contact Phone # |

| VARIANCE/APPROVAL BEING REQUESTED |
|---|
| <p>Check all variances/approvals being requested:</p> <p><input type="checkbox"/> Sterilization – Use of single use disposable products / no autoclave on site</p> <p><input type="checkbox"/> Other (including construction and design) – Describe:</p> <div style="border: 1px solid black; height: 40px; width: 100%;"></div> <p>Ordinance(s), statute or administrative rule requirement(s) for which approval or a variance is being requested:</p> <div style="border: 1px solid black; height: 60px; width: 100%;"></div> <p>General description of the variance being requested and why the request is needed:</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div> <p>Additional steps that will be taken to address potential public health hazards and nuisances:</p> <div style="border: 1px solid black; height: 120px; width: 100%;"></div> |
| Signature Required on Reverse Side |

| OFFICE USE ONLY | | | |
|-----------------|--------------|---------------|----------|
| Initials | Date | Application # | Fee Paid |
| HD Approval | ALD Approval | License # | |

ACKNOWLEDGEMENT & SIGNATURES

I/we understand that all fees must be paid before the application will be reviewed by the Health Department. I/we understand the Health Department has up to 30 days from the date of application to review. Certain variance requests require approval by the State of Wisconsin. These must be sent to the State by the Health Department. (Do not submit requests directly to the state, they will not be accepted.)

I/we acknowledge that Health Department approval of the variance or approval may be conditional and failure to comply with the conditions of approval may result in the variance or approval being revoked. Determination of whether or not the conditions of approval are being met will be assessed as part of routine inspection.

I/we acknowledge that department approvals or variances are only valid for five years from the date of issuance. I must reapply if I wish to renew the variance or department approval. I/we acknowledge that compliance with the statute and the requirements of Chapter 75-23 of the Milwaukee Code of Ordinances is a condition of approval. Noncompliance may result in revocation of my variance or department approval.

Signature of Sole Proprietor, Partner, Agent or 20% or More Shareholder of Corporation or LLC

Signature of Additional Partner(s)

DO NOT WRITE BELOW - FOR OFFICIAL USE ONLY

APPROVALS

Consumer Environmental Health Coordinator or Supervisor Recommendation

Approved Denied
 Approved with Conditions

Comments/Conditions

CEH Coordinator or Supervisor Signature

Date Reviewed

Consumer Environmental Health Director Decision (if required)

Approved Denied
 Approved with Conditions

Director Comments

CEH Director Signature

Date Reviewed

State Review Required

Yes No

Date Submitted

State Review Outcome

Approved Denied
 Approved with Conditions

Date State Reviewed