



TOWN OF TEWKSBURY

BOARD OF HEALTH
@ THE SENIOR CENTER
175 CHANDLER STREET
TEWKSBURY, MASSACHUSETTS 01876

Lou-Ann C. Clement, C.H.O.
Director of Public Health

(978) 640-4470
Fax: (978) 640-4472

Permit No: _____

Fee: \$105.00 (10 beds or less)

APPLICATION FOR TANNING FACILITY LICENSE

Name of Establishment: _____ Date: _____

Address of Establishment: _____

Business Telephone: _____ Fax No: _____

Email Address: _____

Mailing Address (if different) _____

Name of Owner/Corporation: _____

Address of Owner: _____

State _____ Zip Code _____ Home/Corporation Phone: _____

Name of Manager (if different from above): _____

Email Address: _____

Name of Emergency Contact: _____

Address: _____

Phone Number: _____ Cell Phone No: _____

Of Tanning beds: _____ # of other tanning devices _____ Total _____

Tanning Device Information:

Manufacturer	Model#	Model Year	Type of Lamp	Installation date

Board of Health Hours: 7:30 AM to 4:30 PM

Director's Office Hours: Monday – Friday 8:00 AM to 9:30 AM and 2:30 PM to 4:30 PM
Sanitarian Office Hours: Monday – Friday 7:30 AM to 9:00 AM and 3:00 to 4:30 PM

Name of Tanning Device Supplier: _____

Address of Tanning Device Supplier: _____

Name of Tanning Device Installer: _____

Address of Tanning Device Installer: _____

Name of Service Agent: _____

- Attach a copy of the consent form to be used by the facility in fulfilling the requirements of 105 CMR 123.003 (D) (2) & (3).
- Attach a copy of the operating and safety procedures to be followed in the operation of the facility and tanning devices.
- Attach a copy of Worker's Compensation Insurance Affidavit: General Businesses
- Attach a copy of your Insurance Binder

I certify that I have read and understood the requirements of 105 CMR 123.000 and will be responsible for instructing all employees who will responsible for facility and tanning device operation regarding the law.

Pursuant to M.G.L. Chapter 62C section 49A, I certify under the penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

Social Security Number or Federal Identification Number

Signature of Individual or Corporate Officer

_____ Date: _____

Print Name and Title

For Office Use Only: _____

Date Received: _____ Check No: _____ Amount Received: _____

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Sanitarian Office Hours: Monday – Friday 7:30 AM to 9:00 AM and 3:00 to 4:30 PM