



APPLICATION FOR HEALTH DEPARTMENT APPROVAL
Complete and return this form. Address and fax number provided on back of this form.

COMMUNITY SPECIAL EVENTS APPLICATION

Each personal services vendor MUST submit a completed application form to the Durham Region Health Department at least 15 days prior to the event and applications MUST be approved prior to attendance at events. (Photocopies of this form may be made for multiple vendors and can be submitted separately.) Events must comply with applicable sections of the current Personal Services Settings Protocol, under the Health Protection and Promotion Act, R.S.O., 1990 as amended. Note: Failure to receive prior approval may result in closure of premises, or other legal action.

FOR PERSONAL SERVICES VENDORS

EVENT INFORMATION

Event Name: Location (Address) & Municipality:
Date(s) of Operation: (DD/MM/YY - DD/MM/YY) Time(s) of Operation: (e.g. a.m. - p.m.)

VENDOR INFORMATION

Business Name and Address: Operator Name(s) & Home Address(es):
Phone (B): Fax: Phone (H):
Vendor Permit #: (Cell):
Legal Name (i.e. Corporation Name And/Or Number): E-Mail:
Are you a first time participant of a Special Event In Durham Region?
Vendor Set Up:
Outdoor Facility Indoor Facility
If no, name of most recent event you attended in Durham Region:
Event: Dates:
Name of vendor booth and/or booth number at event:

PROVIDE THE FOLLOWING INFORMATION:

Table with 4 columns: Type of Services Provided (e.g. tattooing, body piercing, etc.), Disposable Instruments (Yes/No), Instruments Processed On-site (Yes/No)

Bringing Sterilizer On-site No Yes
Sterilizer Information (e.g. serial number of unit recorded on spore test result must match the unit used at event)
Autoclave
Dry Heat

Where will instruments be cleaned, disinfected, and/or sterilized? ON-SITE OFF-SITE, If off-site, please provide the following:
Name of Premise: Phone No.:
Location (Address):
Relation to Business: OWNER EMPLOYEE OTHER

Instrument Suppliers* - Provide Name/Address/Phone #'s of all suppliers of PRE-PACKAGED, PRE-STERILED INSTRUMENTS
*Attach separate sheet of paper if more space is required
1.
2.
3.
4.

Potable Water Supply:
Municipal Water Commercially Bottled Hauled Municipal Supply (Name & phone # of hauler)
NAME: TEL#:

Waste Water And Garbage Disposal:
Method of Waste Water/Sewage Disposal:
Municipal Other, specify
Number of Garbage Receptacles In Booth: 1 2 Other

Application continued on back of this form.

COMMUNITY SPECIAL EVENTS SURVEY FOR PERSONAL SERVICES VENDORS

This column to be filled out by booth vendor / operator	INSPECTOR COMMENTS (for office use only)
SURVEY QUESTIONS	(Operator Name) contacted on (date / time)
Instruments/Supplies To Be Brought On-Site: (check all that apply) Single-use Disposable <input type="checkbox"/> Sterile Needles <input type="checkbox"/> Sterile Grips / Tubes / Barrels <input type="checkbox"/> Dental bibs <input type="checkbox"/> Sterilization packaging <input type="checkbox"/> Clamps / Forceps <input type="checkbox"/> Ink caps <input type="checkbox"/> Tattoo Stencils <input type="checkbox"/> Applicators <input type="checkbox"/> Gloves <input type="checkbox"/> Razors <input type="checkbox"/> Nail Files <input type="checkbox"/> Nail Buffers <input type="checkbox"/> Others, specify _____	
Reusable <input type="checkbox"/> Grips / Tubes / Barrels <input type="checkbox"/> Tattoo Machine / frame <input type="checkbox"/> Clamps / Forceps <input type="checkbox"/> Scissors <input type="checkbox"/> Cuticle Nippers <input type="checkbox"/> Nail Clippers <input type="checkbox"/> Others, specify _____	
Approved Sharps Container Provided <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hand Hygiene Stations (e.g. hand sinks, hand sanitizer): Locations: <input type="checkbox"/> Washrooms <input type="checkbox"/> Booth <input type="checkbox"/> Portable handwash station <input type="checkbox"/> Other, specify _____ Sink(s) with hot and cold running potable water <input type="checkbox"/> Yes <input type="checkbox"/> No Liquid soap in dispenser <input type="checkbox"/> Yes <input type="checkbox"/> No Single-use paper towels <input type="checkbox"/> Yes <input type="checkbox"/> No Single-use moist towellettes <input type="checkbox"/> Yes <input type="checkbox"/> No Hand sanitizer <input type="checkbox"/> Yes <input type="checkbox"/> No Other, specify _____	
Cleaning and Disinfecting: Name all disinfectants to be used _____ and what they will be used for _____ _____ Test strips provided for disinfectant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Storage of dirty equipment after use _____	
*** Do not complete this section if purchasing prepackaged, presterilized instruments *** Sterilizer: Vendor will provide copy of spore test results processed within 30 days of event <div style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div> Instruments used at the event processed after the above-mentioned passed spore test date <div style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</div> Sterilizer has been challenged with an appropriate spore test and passed consecutively in the last 3 months <input type="checkbox"/> Yes <input type="checkbox"/> No	

The Health Department will contact the operator identified in this application. Approval will be considered only when the Health Department has received all required information on this application form.

I have received and read the Community Special Events information provided. I understand the requirements for personal services vendors at Special Events and have provided the information to all personal service workers that will be working at the event. I agree that all the information I have provided on this application form (2 pages) is accurate.

Print Name: _____ Signature: _____ Date: _____

This report does not purport to set forth all hazards or to indicate that other hazards do not exist at the time services are rendered. By issuing this report, neither the Durham Region Health Department nor any of its employees makes any warranty, express or implied, concerning the property described in this report. Furthermore, neither the Durham Region Health Department nor any of its employees shall be liable in any manner for any personal injury or property damage or loss of any kind arising from or connected with this inspection or failure to inspect.

HEALTH DEPARTMENT USE ONLY	
APPLICATION APPROVED: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Subject to Requirements (see report)	Inspector's Comments/Requirements: _____ _____
DATE: _____	Inspector's Name: _____ Signature: _____
Durham Region Health Department – Environmental Health 101 Consumers Drive, 2 nd Floor, Whitby, ON, L1N 1C4 Phone: 905-723-3818 ext. 2188 Fax: 905-666-1887	Information contained on this form is collected under the authority of the Health Protection and Promotion Act., R.S.O. 1990, Chapter H.7., (as amended) for the purpose of enforcing the Act and Regulations. For information regarding collection, contact the Director of Environmental Health, Durham Region Health Department.