

TATTOO STUDIO PLAN REVIEW INFORMATION REPORT

NOTE : A floor plan showing the location of all equipment, including toilet rooms and fixtures provided therein; and specifications of all equipment including manufacturer and model number MUST accompany this report.

Name of Studio : _____

Studio Address : _____ Telephone : _____

Studio Owner : _____

Owner Address : _____ Telephone : _____

Architect/Engineering Firm : _____

Address : _____ Telephone : _____

Date construction is proposed to start _____, end _____. Proposed opening date _____

GENERAL

1. Number of workstations in studio : _____
2. Number of technicians on any given shift : _____
3. Yes ___ No ___ All doors self-closing?
4. Yes ___ No ___ All outer openings protected against entry of insects and rodents?
5. Yes ___ No ___ Openings in floors, walls, ceilings for pipes, cables and conduits caulked or otherwise protected?

CLEANING ROOM

Make and model number of ultrasonic machine : _____

Make and model number of autoclave : _____

1. Yes ___ No ___ Separate sink provided, reserved for instrument clean up activities only?
2. Yes ___ No ___ Designed to provide distinct, separate areas for cleaning equipment, and for handling and storage of sterilized equipment?
3. Yes ___ No ___ Ultrasonic cleaning unit provided, properly labeled, and placed away from sterilizer and workstations?
4. Yes ___ No ___ Approved autoclave provided?

FLOORS, WALLS, & CEILINGS

List type of materials used or covering:

Floors : _____

Walls : _____

Ceilings : _____

1. Yes ___ No ___ Made of smooth, nonabsorbent and nonporous material, easily cleanable?
2. Yes ___ No ___ Concrete block or other masonry surfaces covered or made smooth and sealed?
3. Yes ___ No ___ Light in color?
4. Yes ___ No ___ Floor/wall junctures sealed and coved in toilet rooms, workstations, and cleaning room?

LIGHTING

1. Yes ___ No ___ Artificial light sources provide 20 foot-candles throughout the facility?
2. Yes ___ No ___ Artificial light sources provide 50 foot-candles in workstations?
3. Yes ___ No ___ Will spot-lighting be utilized to achieve required illumination in workstations?
4. Yes ___ No ___ Artificial light sources shielded or shatterproof in workstations?

REFUSE STORAGE & DISPOSAL

- 1. Yes ___ No ___ Foot-operated receptacles provided in each workstation, sufficient number?
- 2. Yes ___ No ___ Approved sharps container provided in each workstation?
- 3. Yes ___ No ___ Other approved infectious medical waste containers available?
- 4. Yes ___ No ___ Storage of refuse designed to eliminate insect and rodent infestation?
- 5. Yes ___ No ___ Disposal of infectious medical waste by an approved method?

SEWAGE AND LIQUID WASTE DISPOSAL

- 1. Yes ___ No ___ Served by public sewage system?
- 2. Yes ___ No ___ Served by individual sewage system?
- 3. Yes ___ No ___ If yes, is individual sewage system approved by health department?
Date approved : _____
- 4. Yes ___ No ___ Exposed overhead sewage lines?

TOILET FACILITIES

Number of toilets : _____
 Number of lavatories : _____

- 1. Yes ___ No ___ Toilet rooms completely enclosed and doors self-closing?
- 2. Yes ___ No ___ Vented to outside air by mechanical exhaust?
- 3. Yes ___ No ___ Hand sink located inside restroom facility?
- 4. Yes ___ No ___ Located convenient and accessible to technicians and patrons?
- 5. Yes ___ No ___ Provided with hot and cold running water, soap, and single-use towels?

VENTILATION

- 1. Type of ventilation provided : _____
- 2. Yes ___ No ___ Windows to be used for ventilation purposes?
- 3. Yes ___ No ___ If yes, windows appropriately screened?

WATER SUPPLY

- 1. Yes ___ No ___ Served by public water system?
- 2. Yes ___ No ___ Served by individual water system?
- 3. Yes ___ No ___ If yes, is individual water system approved by health department?
Date approved : _____

WORKSTATIONS

- 1. Yes ___ No ___ Separated by solid wall from all other activities?
- 2. Yes ___ No ___ More than one piercing station in one work room?
- 3. Yes ___ No ___ Hand sink with hot and cold running water, operated by wrist or knee action provided in each area?
- 4. Number of hand sinks provided : _____
- 5. Yes ___ No ___ All surfaces made of smooth, non-absorbent, non-porous materials?
- 6. Yes ___ No ___ Cabinet or tightly covered container provided for storage of sterilized instruments only?
- 7. Yes ___ No ___ Storage of chemicals in an approved manner?

Plans and information submitted by :

(Signature)

Title : _____

Date : _____

Telephone : _____