

**ARKANSAS DEPARTMENT OF HEALTH  
COSMETOLOGY SECTION  
4815 West Markham, Slot 8  
Little Rock, AR 72205  
(501) 682-2168**

**ESTABLISHMENT CHANGE OF STATUS APPLICATION**  
**PLEASE PRINT USING BLUE OR BLACK INK**

**INSTRUCTIONS:** The purpose of this form is for any type of change of status to an existing establishment. **Refer to table below for required fee and instructions as to what sections of this application are required. Place an "X" in the box to indicate the type of application.**

**A DUPLICATE LICENSE WILL BE MAILED OUT IN APPROXIMATELY TWO (2) WEEKS.**

**FEE CALCULATION TABLE**

(X)	<u>DESCRIPTION</u>	<u>AMOUNT DUE</u>	<u>SECTIONS TO BE COMPLETED</u>
	CHANGE NAME ONLY	\$75.00	SECTIONS: (A); (B); (D)
	CHANGE OWNER ONLY	\$75.00	SECTIONS: (A); (C); (D)
	CHANGE OWNER AND NAME	\$150.00	SECTIONS: (A); (B); (C); (D)

**SECTION (A) – ESTABLISHMENT INFORMATION CURRENTLY ON FILE  
WITH THE COSMETOLOGY SECTION (PRIOR TO CHANGE)**

Establishment Name				Telephone Number ( )		
Address Where Establishment Receives Mail		Suite #	City	County	State	Zip Code
Physical Address of Establishment		Suite #	City	County	State	Zip Code
Type of Establishment (CIRCLE ONE)	COSMETOLOGY   MANICURE   ELECTROLOGY   AESTHETICS			ID NUMBER	LICENSE NUMBER	
Name of Owner (Corporation or Individual)						

**SECTION (B) – NEW ESTABLISHMENT NAME**

NEW Establishment Name
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**DO NOT WRITE IN THIS AREA – FOR OFFICE USE ONLY**

DATE		ID NUMBER		RECEIPT	
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**SECTION (C) – NEW ESTABLISHMENT OWNER**

**This section requires a 2 x 2 photo of the new owner, a copy of the driver’s license and a legal document, bill of sale or notarized statement from previous owner to support the change of ownership.**

Is the NEW owner a corporation? YES      NO	If yes, name of corporation	If no, is new owner licensed? YES      NO	Id number	License number
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**COMPLETE THE FOLLOWING INFORMATION REGARDING NEW OWNER.**

Last Name		First Name (no nicknames)			Middle Name		SSN		
Date of Birth	Gender (Circle One) MALE    FEMALE	Race (circle one)	Black	White	Am. Indian	Hispanic	Asian	Alaskan Native	
Address Where You Receive Mail			Apt #	City		County	State	Zip Code	
Address Where You Live			Apt #	City		County	State	Zip Code	
Phone (   )									

**SECTION (D) – OWNER CERTIFICATION**

In signing this application, you are certifying that:

1. The information provided on this form is correct to the best of your knowledge.
2. You are the establishment owner or are authorized to act as the owner’s agent.
3. You have read this form, the laws and rules.
4. You have complied with all laws and rules governing cosmological establishments.
5. You will close your establishment if the inspector finds the establishment not in compliance with applicable rules.

Print Owner’s Name	Owner’s Signature	Today’s Date
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DATE		ID NUMBER		RECEIPT	
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