



ALAMEDA COUNTY
HEALTHY NAIL SALON PROGRAM
 1100 San Leandro Blvd, 4th Floor
 San Leandro, CA 94577
 (510) 208-5927 | www.acphd.org/healthynails



HEALTHY NAIL SALON PROGRAM : APPLICATION FORM

Instruction: Please complete the application and submit in person, or via email us or mail to:
 Alameda County's Public Health Department, 1100 San Leandro Blvd, 4th Floor, San Leandro, CA 94577

Section I – Contact Information

Legal Name of Business		
Name of Owner(s)		Name of Contact Person
Business Address		Business License Number & Expiration Date
Telephone	Mobile	Email

Section II – Salon Staff Training (Please attach additional pages if needed)

How many staffs are working in the salon?

Have all of the salon staffs and owner(s) been trained by the Healthy Nail Salon Program **within the past 3 years**?
 YES NO SOME _____ (number staffs trained)

Section III – Products Used (Please attach additional pages if needed)

Nail polish brands/products that DO NOT contain Toxic Trio (Dibutyl phthalate (DBP), Toluene, Formaldehyde)

1)	4)	7)
2)	5)	8)
3)	6)	9)

Nail polish removers (brand and product name)

1)	4)	7)
2)	5)	8)
3)	6)	9)

Nail polish thinners (brand and product name)

1)	4)	7)
2)	5)	8)
3)	6)	9)

Do you display or have on file MSDS (Material Safety Data Sheet) for all products?
 YES NO ONLY SOME MSDS



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Section IV – Procedures

Do all nail technicians wear nitrile or latex gloves when using nail products?

- YES NO SOME

Do you ventilate your space when performing artificial nail services and when using nail thinners and removers?

- YES NO SOME

- I HAVE ATTACHED A PROOF OF PURCHASE (INVOICES)
 I WILL PROVIDE PROOF OF PURCHASE (INVOICES) AND PROOF OF INSTALLATION IN THE FUTURE (Please note the application will be considered)
 MY SALON DOES NOT NEED VENTILATION UNIT

By submitting this application form, I confirm that the information being submitted is accurate and complete, to the best of my knowledge. I understand that program staffs will visit my store to verify the products in use and may conduct air monitoring to measure program success. In addition, program staffs will conduct follow up visit

X _____ DATE: ____ / ____ / ____

SIGNATURE OF OWNER

IF YOU HAVE ANY QUESTIONS REGARDING THIS FORM, PLEASE CONTACT US AT (510) 208-5900