SG-86
Rev. 5/03

West Virginia Department of Health and Human Resources
Bureau for Public Health
_____ Health Department

BODY PIERCING 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 : _____