



Connecticut River Area Health District (CRAHD)

Old Saybrook Clinton Deep River Haddam Chester Killingworth Durham

Salon Plan Review Application Form

Establishment Name: _____

Address: _____

Town: _____ Zip: _____ Phone: _____

Email: _____

Manager Name: _____

Water Supply: ☐ Public Water ☐ Well Water
Sewage: ☐ Sewer ☐ Septic System

Hours of Operation: _____

List all Services and Specify the # of Stations for each Service:

Floor plans required.

I attest that the information supplied on this application is accurate and correct.

Print Name: _____ Signature: _____

Date: _____

Fee: \$200.00

FORM SUBMITTAL: EMAIL OR (MAIL OR DROPOFF COMPLETED FORM)

Email: crahdoffice@crahd.net



Scan & Pay

_____ Check _____ Cash _____ Charge

Phone: (860) 661-3300

Web: www.crahd.info

CT River Area Health District
455 Boston Post Road, Suite #7
Old Saybrook, CT 06475



Connecticut River Area Health District (CRAHD)

Old Saybrook Clinton Deep River Haddam Chester Killingworth Durham

Please ATTACH OR DRAW a floor plan showing the location of all equipment and facilities in the space below

A large, empty rectangular box with a thin orange border, intended for the user to attach or draw a floor plan showing the location of all equipment and facilities.

Phone: (860) 661-3300

Web: www.crahd.info

CT River Area Health District
455 Boston Post Road, Suite #7
Old Saybrook, CT 06475