State of West Virginia
Board of Barbers and Cosmetologists
Tel: (304) 558-2924
Fax: (304) 558-3450
www.wvbbc.com

MAIL COMPLETED APPLICATION TO:

WVBBC
P.O. BOX 40235,
CHARLESTON, WV 25364

APPLICATION FOR REGISTRATION

Initial License Application

Office Use Only

License #	
License Type	
Registered	
Date Passed	

The following must be included with this application:

- ☐ $35.00 Licensure Fee
  Check/Money Order Number: _____
- ☐ Notarized Barber or Cosmetology School Transcript
- ☐ NIC Practical **and** Written Examination Results
- ☐ Copy of High School Diploma/Transcript, GED Diploma/ Transcript, or ATB Exam Results
- ☐ Copy of Photo ID
- ☐ Copy of Social Security Card
- ☐ Clear and Recent Photograph
- ☐ Completed Certificate of Health Form (Page 2)

APPLICANT NOTICE

- Please complete this application in its entirety. Incomplete applications will be returned.
- If you completed your professional training in another State, you must request verification of your training from the State Board where your training was completed. Verifications must be sent directly from the State Board where your training was completed to the West Virginia Board of Barbers and Cosmetologists prior to the submission of this application.
- If your first or last name differs on any documents submitted, you must include official name change documentation such as a copy of your marriage certificate, divorce decree, or other court record.
- Applications are processed within 1-2 weeks upon receipt, and once your application is processed, your license will be mailed to the address provided below.

APPLICANT INFORMATION

License Type: ☐ Cosmetologist ☐ Nail Technician ☐ Barber ☐ Hair Stylist ☐ Aesthetician

Name _____ SSN _____

Address _____ Phone _____

City _____ State _____ Zip Code _____ County _____

E-mail _____ Date of Birth _____

By signing this application, I certify under the penalty of false swearing that the required documentation submitted with this application is true in every respect and that I do not currently owe any child support obligation that is 6 months in arrearages and I am not subject of a child-support subpoena or warrant. I understand that I may be subject to disciplinary action including, but not limited to, immediate revocation or suspension of my professional license by making a false statement or by submitting fraudulent documentation. *Having passed an examination and being otherwise qualified, according to the provisions of Chapter 30, Article 27, Code of West Virginia, I hereby make application for registration for licensure.*

Signed By _____

Current Date _____

Attach Photograph

HERE

Photograph must fit this box and please do not use staples to attach the photograph

Pursuant to W. Va. Code §30-1-27, a person shall be granted an occupational or professional license, registration, or certificate if the person has been licensed or certified in another state, the license, registration, or certificate is in the same discipline and at the same practice level as the license, registration, or certificate for which the person is applying in this state and the person meets other conditions prescribed by W. Va. Code §30-1-27.

Revised: July 2025

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Certificate of Health Form

To the Health Care Professional:
This form should be used for patients who need to be examined by a physician, physician's assistant or a nurse practitioner to apply for a professional license, certificate, registration or permit in the barbering, cosmetology, aesthetics, nail technology or waxing industry. Please complete the below portion of this form and sign and date the form.

To the Applicant:
You need to have a physical examination to apply for a professional license, certificate, registration or permit in barbering, cosmetology, aesthetics, nail technology or waxing. Your physician, physician's assistant or a nurse practitioner must complete, sign and date this Certificate of Health form. You must submit your application within one (1) year from the date of this examination.

Certificate of Health:

I am a duly licensed Physician [ ], duly licensed Physicians Assistant [ ], or duly licensed Nurse Practitioner [ ], and hereby state that in the course of a routine examination of _____ ,on
(Applicant's Name)

_____ . I found no clinical evidence of the presence of infectious or communicable disease which would pose a significant risk or direct threat to the health or safety of members of the public in the conduct of the applicant's occupation.
(Date of Physical Examination)

Print Name of Physician: _____ Date: _____

Address of Practice: _____

Physician's Signature: Title: _____