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/Cosmetology School Transcripts
- ☐ NIC Practical & Written Examination Results
- ☐ Copy of High School Diploma/GED Diploma/ATB Results
- ☐ Copy of Valid Photo ID
- ☐ Copy of Social Security Card
- ☐ Passport-Sized Photo
- ☐ Certificate of Health Form

APPLICANT NOTICE

*If you completed your professional training in another State, you must request verification of your training hours from the State Licensing Board where your training was completed. Verifications must be sent directly from the State Licensing Board to the West Virginia Board of Barbers and Cosmetologists prior to the submission of this application. School Transcripts alone will not be accepted.
*If your name differs on any documents submitted, you must include official name change documentation (i.e., marriage license/certificate, divorce decree, or court order).
*Please complete the form in its entirety. All incomplete applications will be returned.

APPLICANT INFORMATION

License Type: ☐ Cosmetologist ☐ Barber - All Types ☐ Aesthetician ☐ Nail Technician ☐ Hair Stylist

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 be clear and recent

Please do not use staples

This application contains Personally Identifiable Information (PII). The SSN number collected within this application is to manage your license account by effectively identifying your information and **will not** be shared with a third-party. The information collected on this application will be securely protected through the Board's server database. By submitting this application, I agree to the policy.

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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
(Date of Physical Examination)

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.

Print Name of Physician: _____ Date: _____

Address of Practice: _____

Physician's Signature: Title: _____