



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

MAIL COMPLETED APPLICATION TO:

WVBCC
P.O. BOX 40235
CHARLESTON, WV 25364

INSTRUCTOR CERTIFICATION APPLICATION

Please attach the following:

- \$50.00 Fee
- Copy of Social Security Card
- Copy of Photo ID
- Passport-Sized Photo
- Completed Certificate of Health form (see page 2)
- Official Certificate/Transcripts from Teaching Techniques Seminar
- Copy of NIC Instructor Examination Results

Office Use:

Instructor #

Please complete the following:

- | | | |
|-----------------|-------------|--------------|
| Aesthetics | Cosmetology | Hair Styling |
| Nail Technology | Barber | Waxing |

Name SSN #

Address

City State Zip Code

Email Phone Number

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.

With my signature below, I submit my application for an instructor's certification. I also affirm that all information within this application and attached documents are true in every respect.

Signature

Date

Attach Passport-Sized Photograph Here



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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: _____