KHAIR Salon/Barber Shop Application Form

Salon/Barber shop name : ______________________________

Address : ______________________ City : ____________ Zip : ________

Telephone # : ______________________ Fax : ______________________

Contact person : ______________________________

Are you the : ❑ Owner ❑ Manager ❑ Stylist

Does your Salon/Barber shop service : ❑ Men ❑ Women ❑ Both

Is your salon insured? ❑ Yes ❑ No

Insurance company : ________________ Policy expiration date : ________________

Have any of your salon employees been convicted of a felony? ❑ Yes ❑ No

If yes, please explain : ______________________________

Are you open to providing care for more than one child? ❑ Yes ❑ No

If so, how many? ________ When can you start receiving a KHAIR Kid? ________________

How did you hear about the KHAIR program? ______________________________

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When is the best day/time for our KHAIR coordinator to contact you? ________________

I authorize whatever inquiries CHNCT/Clifford Beers Clinic/Village for Children and Families deem necessary to any person, institution, company, or organization to verify any of the information given in this application or in connection with it, and to otherwise determine my qualifications and abilities. I release such persons, institutions, companies or other organizations from any liability due to responding to inquiries.

Please read before signing to ensure that all questions on this application have been answered correctly. If you have any questions regarding this or any other employement form, please ask them before signing. I hereby acknowledge that I have read the above statement and understand it.

Signature : ______________________ Date application received : ________________

Please return this application by mail to: Bianca Miranda, Community Relations Specialist
Community Health Network of Connecticut, Inc.
11 Fairfield Blvd., Suite 1
Wallingford, CT 06492

Or return by fax to: 203-265-3705

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