

Approved by
the Florida State Board of Cosmetology

Florida 12 Hour Initial Licensure Course for Body Wrapping

Presented by
ContinuingCosmetology.com
PO Box 691296
Orlando, FL 32869

T. D. Costner
Cosmetology Instructor / Program Director
info@continuingcosmetology.com
407.435.9837

Florida 12 Hour Initial Licensure Course for Body Wrapping (12 hours)
TABLE OF CONTENTS

Page

LESSON 1: <u>Initial HIV/AIDS and Other Communicable Diseases</u> (3 hours)	2
(a) Modes of Transmission	
(b) Infection Control Procedures	
(c) Clinical Management	
(d) Prevention of HIV and AIDS	
(e) Attitudes towards HIV and AIDS	
(f) Appropriate behavior in dealing with persons who may have the virus or syndrome	
LESSON 2: <u>Sanitation and Sterilization</u> (4 hours)	25
(a) Universal Sanitation and Sterilization Precautions	
(b) How to distinguish between disinfectants and antiseptics	
(c) How to sanitize hands and disinfect tools used in the practice of Cosmetology and Body Wrapping	
LESSON 3: <u>Diseases and Disorders of the Skin</u> (4 hours)	47
LESSON 4: <u>State and Federal Laws as they pertain to Cosmetologists, Cosmetology, Salons, Specialists, Specialty Salons, and Booth Renters: Chapter 477, F.S. And the Rules of the Board.</u> (1 hour)	68
(a) The Laws and Rules of the Board that protect the Health, Safety and Welfare of the Consumer	
(b) The Laws and Rules of the Board that determine where and when individuals may legally practice Cosmetology and Specialties	
(c) The Functions of the Board of Cosmetology, how its member are appointed, and their duties	
(d) The Laws and Rules of the Board which specify prohibited conduct and the penalties for failure to follow the laws and rules	
(e) Salon Requirements and Inspections	
(f) The dates, Fees, and Requirements for renewal of Cosmetology licenses, salon licenses and specialty registrations	
Open Book Test	104
Course Evaluation Form	107
Registration Information Form	108

LESSON 1: Initial HIV/AIDS and Other Communicable Diseases (3 hours)

(a) Modes of Transmission

Objectives:

- Define HIV and AIDS
- Identify the origination of HIV and AIDS
- Explain how HIV is transmitted
- Identify Other Communicable Diseases

(b) Infection Control Procedures

Objectives:

- List the symptoms of HIV infection
- Define ways to avoid infecting others

(c) Clinical Management

Objectives:

- Describe the reliability of HIV testing
- Describe the stages of HIV infection
- List the types of studies and clinical trials performed by the AIDS Healthcare Foundation
- List opportunistic infections related to AIDS
- Define the term antiretroviral

(d) Prevention of HIV and AIDS

Objectives:

- List pro-active measures that help prevent HIV infection
- List the diseases that condoms are reported to protect against

(e) Attitudes towards HIV and AIDS

Objectives:

- Describe issues of behavior and communication concerning HIV
- List the considerations that a person with HIV has on a personal level
- List the considerations that a person with HIV has on a professional level

(f) Appropriate behavior in dealing with persons who may have the virus or syndrome

Objectives:

- Describe the International Labor Organization's role regarding workplace attitudes
- Explain the US Dept. of Labor's SHARE program
- Define the Share program's effectiveness

(a) Modes of Transmission

➤ HIV/AIDS Defined

HIV is the **acronym** (a word formed from the initial letters or groups of letters of words in a set phrase or series of words) for **H**uman **I**mmunodeficiency **V**irus. This virus causes AIDS. **Being infected with HIV, however, is not the same as having AIDS.** People who have tested positive for HIV have been known to stay healthy for years, even decades, with proper treatment. Over time, in many cases, a long time, HIV slowly weakens the immune system until AIDS develops.

AIDS is the **acrostic** (first, last, or other particular letters when taken in order spell out a word or phrase) for **A**cquired **I**mmunode**f**iciency **S**yndrome. In medicine, a syndrome is a group of symptoms that all together indicate the presence of a disease. When a person has AIDS, his or her body has been weakened to the point where it is not longer able to effectively fight disease. As a result, many other health problems develop when a person has AIDS.

➤ **Origination**

In the United States, AIDS and HIV hit the headlines in the early 1980s. In 1982, public health officials began using the term “acquired immunodeficiency syndrome” or AIDS.

Formal tracking of AIDS cases in the United States began in 1982. The following year, scientists participating in an international committee discovered HIV as the cause of AIDS.

With time and research, it has become clear that HIV and AIDS existed decades before 1982. In the mid- to late-1970s, doctors in Los Angeles and New York noted growing numbers of gay men developing rare types of pneumonia, cancer and other illnesses.

An analysis of a blood sample taken from a man in 1959 in Kinshasa, Democratic Republic of Congo, uncovered HIV-1. (**HIV-1 is the most widespread type of HIV in the developed world.**) Genetic analysis of the blood sample suggests that HIV-1 may have developed from a single virus in the late 1940s or early 1950s.

Precisely how and when HIV came to exist is still being studied. In 1999, an international research team discovered HIV-1 in a group of chimpanzees native to west equatorial Africa. They have suggested that HIV-1 spread to humans when hunters became exposed to infected chimpanzee blood.

➤ **HIV is transmitted by:**

- ▶ Having unprotected (sex without a condom) sexual intercourse (vaginal or anal) with someone who has HIV.
- ▶ Having unprotected oral sex with someone who has HIV. The risk goes up if there is ejaculation in the mouth. The risk rises still higher if either partner has cuts or sores in the mouth from recent tooth brushing, bleeding gums, canker sores or other sexually transmitted diseases (STDs)
- ▶ Sharing needles or syringes with someone who is HIV infected
- ▶ Sharing needles, syringes or drug works with someone infected with HIV
- ▶ Pregnancy, childbirth or breast-feeding if the mother has HIV infection

HIV is spread only when someone is exposed to blood, semen, vaginal fluid or mother's milk from someone who is infected with HIV. The virus doesn't live long in the open environment outside the body.

There is virtually no evidence that HIV infection can be spread from tears or sweat. Even saliva has a very little viral content. (The risk goes up, however, if either person has blood in their mouth from cuts, open sores or gum disease.)

HIV infection can't be spread by day-to-day contact at work, school or social settings. Shaking someone's hand, hugging them, using the same toilet, drinking from the same glass, being nearby when someone with HIV coughs or sneezes – none of these activities spreads HIV infection. Even open-mouthed kissing is relatively low risk.

During a mosquito bite, the mosquito injects its own saliva into the person it is biting. It is not injecting blood from the last person the mosquito bit. Mosquito saliva can carry infections such as malaria, dengue fever, yellow fever or West Nile virus. That is how a person can get those infections from a mosquito bite. HIV cannot be transmitted in that way.

The chance of getting infected while being tattooed is low because HIV can't survive well in the open air. Tattooing if precautions aren't used can spread other diseases, including hepatitis. Using disposable needles, proper cleaning and sterilization of equipment eliminates much of the infection risk from tattooing.

While a woman with HIV who is pregnant can spread the virus to her child during childbirth or pregnancy, it doesn't happen as often as you might expect. A pregnant woman with HIV who receives no treatment at all, will give birth to an HIV-infected baby about 25% of the time. With today's antiretroviral therapy, however, the rate of transmission from mother to child has dropped to about 2%.

Estimated numbers of AIDS cases and deaths 2002-2006

Year	Estimated Number of AIDS Cases	Estimated Number of Deaths Among Persons with AIDS
2006	36,828	14,016
2005	36,552	16,268
2004	37,726	16,395
2003	38,538	16,690
2002	38,132	16,948

HIV Incidence Estimate

Incidence is the number of new HIV infections that occur during a given year.

In 2008, CDC estimated that approximately 56,300 people were newly infected with HIV in 2006 (the most recent year that data are available). Over half (53%) of these new infections occurred in gay and bisexual men. Black/African American men and women were also strongly affected and were estimated to have an incidence rate that was 7 times as high as the incidence rate among whites.

AIDS Cases

In 2007, the **estimated number** of persons diagnosed with AIDS in the United States and dependent areas was **37,041**. Of these, **35,962** were diagnosed in the 50 states and the District of Columbia and **812** were diagnosed in the dependent areas.

In the 50 states and the District of Columbia, adult and adolescent AIDS cases totaled **35,934** with **26,355** cases in males and **9,579** cases in females, and **28** cases estimated in children under age 13 years.

The cumulative **estimated number** of diagnoses of AIDS through 2007 in the United States and dependent areas was **1,051,875**.

Of these, **1,018,428** were diagnosed in the 50 states and the District of Columbia and **32,051** were diagnosed in the dependent areas.

In the 50 states and the District of Columbia, adult and adolescent AIDS cases totaled **1,009,220** with **810,676** cases in males and **198,544** cases in females, and **9,209** cases estimated in children under age 13 years.

These numbers do not represent reported case counts. Rather, these numbers are point estimates, which result from adjustments of reported case counts.

The reported case counts have been adjusted for reporting delays and for redistribution of cases in persons initially reported without an identified risk factor, but not for incomplete reporting.

Totals include persons of unknown race or multiple races, persons of unknown sex, and persons of unknown state of residence.

AIDS Cases by Age

Of the **estimated number** of persons diagnosed with AIDS in the 50 states and the District of Columbia, persons' ages at time of diagnosis were distributed as follows.

Age (Years)	Estimated # of AIDS Cases in 2007	Cumulative Estimated # of AIDS Cases, Through 2007*
Under 13	28	9,209
Ages 13-14	80	1,169
Ages 15-19	455	6,089
Ages 20-24	1,927	38,175
Ages 25-29	3,380	120,464
Ages 30-34	4,187	201,906
Ages 35-39	5,888	219,601
Ages 40-44	6,813	177,250
Ages 45-49	5,749	112,896
Ages 50-54	3,636	63,408
Ages 55-59	2,040	34,160
Ages 60-64	980	18,249
Ages 65 or older	800	15,853

*Includes persons with a diagnosis of AIDS from the beginning of the epidemic through 2007.

AIDS Cases by Race/Ethnicity

CDC tracks HIV/AIDS information on six racial and ethnic groups: American Indian/Alaska Native; Asian; Black/African American; Hispanic/Latino; Native Hawaiian/Other Pacific Islander; and White.

Estimated numbers of AIDS cases in the 50 states and the District of Columbia, by race or ethnicity:

Race or Ethnicity	Estimated # of AIDS Cases in 2007	Cumulative Estimated # of AIDS Cases, Through 2007*
American Indian/Alaska Native	158	3,492
Asian ^a	475	7,511
Black/African American	17,507	426,003
Hispanic/Latino ^b	6,921	169,138
Native Hawaiian/Other Pacific Islander	76	721
White	10,407	404,465

*Includes persons with a diagnosis of AIDS from the beginning of the epidemic through 2007.

^aIncludes Asian/Pacific Islander legacy cases.

^bHispanics/Latinos can be of any race.

➤ Tuberculosis & HIV

Tuberculosis, also known as TB, is the leading infectious killer of people living with HIV, and accounts for an estimated 13% of AIDS deaths worldwide. HIV and TB are so closely connected that they are often referred to as co-epidemics or dual epidemics.

The epidemics drive and reinforce one another: HIV activates dormant TB in a person, who then becomes infectious and able to spread the TB bacillus to others.

Untreated, someone with active tuberculosis will infect an estimated 10 to 15 people per year.

The Stop TB Strategy is the internationally recommended standard for preventing, diagnosing and treating TB and includes recommendations for managing TB in people living with HIV.

Recently a new TB strain, extensively drug resistant TB (XDR TB), has emerged, which is particularly dangerous for people living with HIV in whom it is frequently fatal.

Preventing the development and spread of drug resistant TB through greater investment in TB services, improved community case finding and adherence support, and more effective infection control are essential.

To appropriately respond to both epidemics and avoid more widespread drug resistance, care and prevention of both diseases should be priority concerns of all TB and HIV programs. UNAIDS, the Stop TB Partnership and the World Health Organization (WHO) are together encouraging a concerted, coordinated global effort to control TB in people living with HIV.

In addition, [the Stop TB Partnership has formed the TB/HIV Working Group, which develops global policy on the control of HIV-related TB and advises on how those fighting against TB and HIV can work together.

These partnerships have led to the creation of policies and guidelines to deal with HIV-related TB, and countries and organizations have taken important steps towards integrating their HIV and TB responses.

However, more collaborative action is needed to widely implement programs, including those that:

- ✓ Offer HIV testing and counseling to all TB patients
- ✓ Screen all people living with HIV for TB disease
- ✓ Provide TB treatment or preventive therapy to all co-infected people
- ✓ Provide cotrimoxazole and antiretroviral treatment to all TB patients with HIV
- ✓ **Ensure TB infection control in all health care facilities and high HIV prevalence settings**

Latent TB Infection and TB Disease

Not everyone infected with TB bacteria becomes sick. As a result, two TB-related conditions exist: latent TB infection and active TB disease.

Latent TB Infection

TB bacteria can live in your body without making you sick. This is called **latent TB infection (LTBI)**. In most people who breathe in TB bacteria and become infected, the body is able to fight the bacteria to stop them from growing. People with latent TB infection do not feel sick and do not have any symptoms.

The only sign of TB infection is a positive reaction to the tuberculin skin test or special TB blood test. People with latent TB infection are not infectious and cannot spread TB bacteria to others. However, if TB bacteria become active in the body and multiply, the person will get sick with TB disease.

TB Disease

TB bacteria become active if the immune system can't stop them from growing. When TB bacteria are active (multiplying in your body), this is called **TB disease**.

TB disease will make you sick. People with TB disease may spread the bacteria to people they spend time with every day. Many people who have latent TB infection never develop TB disease.

Some people develop TB disease soon after becoming infected (within weeks) before their immune system can fight the TB bacteria. Other people may get sick years later, when their immune system becomes weak for another reason.

For persons whose immune systems are weak, especially those with HIV infection, the risk of developing TB disease is much higher than for persons with normal immune systems.

The Difference between Latent TB Infection and TB Disease

A Person with Latent TB Infection	A Person with TB Disease
<ul style="list-style-type: none"> • Has no symptoms 	<ul style="list-style-type: none"> • Has symptoms that may include: <ul style="list-style-type: none"> - a bad cough that lasts 3 weeks or longer - pain in the chest - coughing up blood or sputum - weakness or fatigue - weight loss - no appetite - chills - fever - sweating at night
<ul style="list-style-type: none"> • Does not feel sick 	<ul style="list-style-type: none"> • Usually feels sick
<ul style="list-style-type: none"> • Cannot spread TB bacteria to others 	<ul style="list-style-type: none"> • May spread TB bacteria to others
<ul style="list-style-type: none"> • Usually has a skin test or blood test result indicating TB infection 	<ul style="list-style-type: none"> • Usually has a skin test or blood test result indicating TB infection
<ul style="list-style-type: none"> • Has a normal chest x-ray and a negative sputum smear 	<ul style="list-style-type: none"> • May have an abnormal chest x-ray, or positive sputum smear or culture
<ul style="list-style-type: none"> • Needs treatment for latent TB infection to prevent active TB disease 	<ul style="list-style-type: none"> • Needs treatment to treat active TB disease

➤ HIV/AIDS and Viral Hepatitis

Hepatitis B Testing and Vaccination

Hepatitis B virus (HBV) and human immunodeficiency virus (HIV) are bloodborne viruses transmitted primarily through sexual contact and injection drug use.

Because of these shared modes of transmission, a high proportion of adults at risk for HIV infection are also at risk for HBV infection. HIV-positive persons who become infected with hepatitis B virus (HBV) are at increased risk for developing chronic HBV infection and should be tested.

In addition, persons who are co-infected with HIV and HBV can have serious medical complications, including an increased risk for liver-related morbidity and mortality.

To prevent HBV infection in HIV-infected persons, the Advisory Committee on Immunization Practices recommends universal hepatitis B vaccination of susceptible patients with HIV/AIDS.

Hepatitis C and HIV/AIDS Co-Infection

About one quarter of HIV-infected persons in the United States are also infected with hepatitis C virus (HCV).

HCV is a bloodborne virus transmitted through direct contact with the blood of an infected person. Thus, co-infection with HIV and HCV is common (50%–90%) among HIV-infected injection drug users. HCV is one of the most important causes of chronic liver disease in the United States and HCV infection progresses more rapidly to liver damage in HIV-infected persons.

HCV infection may also impact the course and management of HIV infection. The U.S. Public Health Service/Infectious Diseases Society of America guidelines recommend that all HIV-infected persons be screened for HCV infection.

Hepatitis A - is an acute liver disease caused by the hepatitis A virus (HAV), lasting from a few weeks to several months. It does not lead to chronic infection.

Transmission: Ingestion of fecal matter, even in microscopic amounts, from close person-to-person contact or ingestion of contaminated food or drinks.

Vaccination: Hepatitis A vaccination is recommended for all children starting at age 1 year, travelers to certain countries, and others at risk.

Hepatitis A	2006	2005	2004	2003	2002	2001
No. of Acute Clinical Cases Reported	3,579	4,488	5,683	7,653	8,795	10,616
Estimated No. of Acute Clinical Cases	15,000	19,000	24,000	33,000	38,000	45,000
Estimated No. of New Infections	32,000	42,000	56,000	61,000	73,000	93,000

Hepatitis B - is a liver disease caused by the hepatitis B virus (HBV). It ranges in severity from a mild illness, lasting a few weeks (acute), to a serious long-term (chronic) illness that can lead to liver disease or liver cancer.

Transmission: Contact with infectious blood, semen, and other body fluids from having sex with an infected person, sharing contaminated needles to inject drugs, or from an infected mother to her newborn.

Vaccination: Hepatitis B vaccination is recommended for all infants, older children and adolescents who were not vaccinated previously, and adults at risk for HBV infection.

Hepatitis B	2006	2005	2004	2003	2002	2001
No. of Acute Clinical Cases Reported	4,758	5,494	6,212	7,526	8,064	7,844
Estimated No. of Acute Clinical Cases	13,000	15,000	17,000	22,000		
Estimated No. of New Infections	46,000	51,000	60,000	73,000	79,000	78,000

Hepatitis C - is a liver disease caused by the hepatitis C virus (HCV). HCV infection sometimes results in an acute illness, but most often becomes a chronic condition that can lead to cirrhosis of the liver and liver cancer.

Transmission: Contact with the blood of an infected person, primarily through sharing contaminated needles to inject drugs.

Vaccination: There is no vaccine for hepatitis C.

Hepatitis C	2006	2005	2004	2003	2002	2001
Estimated No. of Acute Clinical Cases	3,200	3,400	4,200	4,500	4,800	3,900
Estimated No. of New Infections	19,000	21,000	26,000	28,000	29,000	24,000

Hepatitis D - is a serious liver disease caused by the hepatitis D virus (HDV) and relies on HBV to replicate. It is uncommon in the United States.

Transmission: Contact with infectious blood, similar to how HBV is spread.

Vaccination: There is no vaccine for hepatitis D.

Hepatitis E - is a serious liver disease caused by the hepatitis E virus (HEV) that usually results in an acute infection. It does not lead to a chronic infection. While rare in the United States, hepatitis E is common in many parts of the world.

Transmission: Ingestion of fecal matter, even in microscopic amounts; outbreaks are usually associated with contaminated water supply in countries with poor sanitation.

Vaccination: There is currently no FDA-approved vaccine for hepatitis E.

➤ STDs and Viral Hepatitis

Hepatitis A

Transmission of hepatitis A virus (HAV) during sexual activity occurs due to fecal-oral contact or contamination. Measures typically used to prevent the transmission of other STDs (e.g., use of condoms) do not prevent HAV transmission. Vaccination is the most effective means of preventing HAV transmission among persons at risk for infection.

Hepatitis B

Among adults seeking treatment in STD clinics, as many as 10%–40% have evidence of past or current hepatitis B virus (HBV) infection. Many of these infections could have been prevented through universal vaccination during delivery of STD prevention or treatment services. A study of adults diagnosed with acute hepatitis B found that 39% had sought care or been screened for an STD before they were infected with HBV, indicating a significant missed opportunity to vaccinate at-risk persons when they first access STD prevention or treatment services.

Hepatitis C

Although not common, hepatitis C virus (HCV) can be transmitted through sexual activity. The factors found to be associated with sexual transmission of HCV are sex with multiple partners, presence of other STDs, or sex with trauma.

Case-control studies have reported an association between acquiring HCV infection and exposure to a sex contact with HCV infection or exposure to multiple sex partners. Surveillance data also indicate that 15%–20% of persons reported with acute HCV infection have a history of sexual exposure in the absence of other risk factors.

(b) Infection Control Procedures

➤ Know the Signs of HIV/AIDS

One thing that has allowed HIV infection to spread so far so fast is the lack of symptoms at first. **Many people infected with HIV for 10 or more years have no symptoms of illness.** They can still infect other people during this time unless they practice safe sex.

The only way to know if you are infected is to be tested. Because a test is a snapshot of your health at one given time, it is wise to be tested periodically. It can take three to five months from exposure to HIV infection to when HIV can be found in a blood test.

When HIV infection begins to make an **impact on a person's immune system**, he or she may show **signs** such as:

- A deep tiredness that cannot be explained
- A dry cough
- A fever that comes and goes
- **Blotches that can be red, brown, pink or purplish under the skin or inside the mouth, nose or eyelids**
- Diarrhea that lasts for more than a week
- Heavy night sweats
- Memory loss, depression or other neurological disorders
- Rapid weight loss
- Swollen lymph glands in the armpits, groin or neck
- White spots or odd blemishes on the tongue, mouth or throat

Having these symptoms doesn't mean a person has HIV or AIDS. Many illnesses have symptoms like these. Only an HIV test can make certain whether a person has HIV or not.

The AIDS Healthcare Foundation operates the largest private HIV and STD testing program in California. It also offers testing in Florida. These testing facilities can be found in a variety of settings, including mobile vans.

You can also ask your health care provider to give you an HIV test.

As with other diseases, the earlier HIV infection is discovered, the more effectively it can be treated.

➤ **Telling Others You Have HIV**

Knowing who to tell when you learn that you have HIV can be a challenge. You may not feel like telling anyone. On the other hand, letting the right people know can help you feel better. You won't have to keep secrets from those close to you. You'll be able to talk about what's in your mind and important to you.

It's extremely important that you:

- Tell anyone with whom you have had sex. This can be difficult. It's essential that they be told so they can be tested and get treatment, if necessary. Knowing if they have HIV can help them from spreading it to others.
- **Tell anyone you plan to have sex with.** Practicing safe sex will help protect your health and that of any partners. In some states, not telling a sexual partner you have HIV before having sex is a felony.
- Tell your doctor and dentist. This helps them give you the right kind of care. As medical professionals, they have an obligation to keep this information private and confidential. A doctor or dentist cannot refuse to treat you because you have HIV.

It can be difficult to tell others. Some people may not be well informed about HIV. They may find it hard to accept that you have this disease. Some people may end their friendship with you or reject you in a dating situation. Often, you won't know how someone will respond until you tell him or her.

(c) Clinical Management

You can have – and spread – HIV for up to 10 years without having any symptoms of HIV or AIDS. HIV affects each individual differently. It is possible to look and feel healthy for years. The only sure way to know if you have HIV infection is to get tested.

Today, testing for HIV is more reliable than tests for many other diseases. The accuracy in establishing whether a person does – or does not – have HIV infection is quite high and reliable. Usually when a test comes back HIV positive, the test is repeated or other test are done to check for viral genetic material in body fluids and cells to confirm the first test results.

Knowing if you have HIV, gives you the power to seek treatment when it will be most effective. It also makes it possible for you to avoid spreading the infection to others.

➤ **How HIV Progresses to AIDS**

People commonly talk as if there is the infection (HIV) and then there is the disease (AIDS). HIV actually has several stages. HIV can move through these stages slowly or quickly.

Studies of people who don't receive treatment for HIV show that about half of HIV-infected people progress to AIDS within 10 years of being infected. Three out of four HIV-infected people progress to AIDS within 15 years of infection.

Children who are born with HIV and people who got HIV through a blood transfusion tend to get sick more quickly.

The stages of HIV tend to follow the pattern highlighted below, although actual times vary a great deal from one person to another:

Time After Infection	Stage
3 to 6 months	HIV spreads within the body and becomes detectable when an HIV test is done.
1 to 10 years	A person is HIV, but healthy.
3 to 10 years	Minor symptoms may appear.
8 to 12 years	Symptoms of HIV or AIDS begin to appear.

➤ **When HIV Becomes AIDS**

AIDS is the last stage of HIV-infection. A doctor can make the diagnosis of HIV infection that has become AIDS. **This diagnosis is based on guidelines established by the Centers for Disease Control.**

Since 1996, powerful virus-fighting drugs have been introduced that dramatically delay the progression of HIV to AIDS. Other new treatments and drugs are now being used to treat illnesses associated with AIDS.

➤ **Clinical Trials**

- **Biomedical research**

is biological research in the interests of medicine and it typically involves human subjects at various stages in the development of drugs, vaccines or techniques. By its very nature, biomedical research raises myriad ethical issues, which become increasingly complex as medicine advances and the scope of research and clinical trials widens internationally.

In 1964, the World Medical Association issued The Declaration of Helsinki, which set out ethical guidelines for physicians engaged in biomedical research. Updated periodically, the declaration is the fundamental document in this field and has influenced the formulation of international, regional, and national legislation and codes of conduct.

Before prospective products come to human trials, they are developed and tested for safety using animal models, in the laboratory. The data obtained from laboratories form the basis on which decisions are made regarding human trials and registration of new drugs for use in the health services. It is imperative therefore that the data be high quality, rigorous and trustworthy, and WHO is in the forefront of setting standards for good laboratory practice.

- **Nutritional Care**

Good nutrition plays an important role in maintaining the health of people living with HIV. Adequate nutrition is essential to maintain a person's immune system, to sustain healthy levels of physical activity, and for quality of life. Adequate nutrition is also necessary for optimal benefits from antiretroviral therapy.

In many of the countries most heavily affected by HIV, food scarcity and poverty make adequate nutrition nearly impossible.

Food is part of a comprehensive antiretroviral therapy package and food and nutrition support needed into programs for the prevention of mother-to-child transmission.

Such assistance not only contributes to the health of HIV-infected mothers and their newborns, but also helps reduce economic burdens associated with childbirth and HIV infection.

Nutrition should become an integral part of the countries response to HIV. In particular, UNAIDS Program recommend strengthening political commitment to nutrition and HIV within the national health agenda, reinforcing nutrition components in HIV policies and programs, and incorporating HIV issues into national nutrition policies and programs.

One of the populations most vulnerable to malnutrition due to food scarcity and poverty is children, especially infants. Lack of breastfeeding exposes children to increased risk of malnutrition and life-threatening infectious diseases other than HIV, especially in the first year of life.

The United Nations recommends that infants be exclusively breastfed for the first six months of life, and that thereafter infants should receive nutritionally adequate and safe complementary foods while breastfeeding for up to 24 more months.

However, breastfeeding by HIV-infected mothers significantly increases the risk of HIV transmission to the infant. Therefore, when replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV infected mothers is recommended.

Otherwise, exclusive breastfeeding is recommended during the first months of life and should then be discontinued as soon as it is feasible.

To help HIV-positive mothers make the best choice, they should receive counseling and have access to follow-up care and support, including nutritional support.

- **Caregiver**

The strains on those caring for people living with HIV are enormous, and without adequate and reliable support the risk of 'burnout' is high.

Much of the stress experienced by carers is in the nature of the work itself—they are dealing with a disease that kills largely young people and is heavily stigmatized, and most carers in poor countries do not have the means to provide life saving treatment which is widely available in high-income countries.

Managing stress and burnout requires measures to strengthen the capacity of the individual carer to cope with the duties and responsibilities of the role.

It means ensuring that the working conditions, policies and practices of care programs offer a supportive environment. And it means advocating national policies and laws that are sensitive to the needs of carers.

Antiretroviral drugs are medications for the treatment of infection by retroviruses, primarily HIV.

AIDS Healthcare Foundation (AHF) has over ten years of experience with anti-retroviral (ARV) studies, including:

- **Studies of new ARV medications, both before and after FDA approval**
- Studies for people who already take ARV medications and are failing, as well as studies for people who have not yet begun ARV therapy
- Studies comparing different combinations of ARV medications
- Studies to reduce the number of pills a person must take, and to reduce dosing frequency
- Women's studies, looking at the quality of life for women with HIV
- Studies examining obstacles that prevent people from taking their ARV medications as prescribed
- Research into related conditions such as Hepatitis C and neurological disorders

Anti-retroviral therapy doesn't cure AIDS, nor does it prevent the spread of HIV. Antiretrovirals do, however, extend life and improve the quality of life while living with HIV.

As HIV progresses, the immune system becomes weakened. The body isn't able to defend itself against common bacteria and viruses that a healthy immune system can do easily.

These are called opportunistic infections because they take advantage of the weakened immune system. If you are on antiretroviral therapy, you can go along time before developing opportunistic infections.

Some of the more common opportunistic infections are:

- **Cryptosporidiosis (Crypto)** - a disease caused by protozoan parasites of the genus *Cryptosporidium*, characterized by fever and gastrointestinal symptoms and typically spread via contaminated drinking water.
- **Cytomegalovirus (CMV)** - a common virus of the herpes virus family, usually harmless or causing mild colds but capable of producing severe systemic damage in infected newborns and immunosuppressed persons.
- **Hepatitis C (Hep C)** - inflammation of the liver, caused by a virus or a toxin and characterized by jaundice, liver enlargement, and fever.
- **Human papilloma virus (HPV)** - a species of virus that causes genital warts.
- **Mycobacterium avium complex (MAC)**- MAC bacteria are common in the environment and cause infection when inhaled or swallowed. Symptoms of MAC diseases are reminiscent of tuberculosis. They include fever, fatigue, and weight loss. Pulmonary involvement is similar to TB, while diarrhea and abdominal pain are associated with gastrointestinal involvement. MAC should always be considered in a person with HIV infection presenting with diarrhea.
- **Pneumocystis carinii pneumonia (PCP)**- a pulmonary infection caused by the protozoan *Pneumocystis carinii*, occurring as an opportunistic disease in persons with impaired immune systems, as AIDS victims.

- Toxoplasmosis (**Toxo**)- infection with the parasite *Toxoplasma gondii*, transmitted to humans by consumption of insufficiently cooked meat containing the parasite or by contact with contaminated cats or their feces: the illness produced is usually mild, but in pregnant women may damage the fetus.
- **Tuberculosis (TB)**- an infectious disease that may affect almost any tissue of the body, esp. the lungs, caused by the organism

Antiretroviral drugs:

Anti-retroviral drugs are powerful. Taken in combinations of two or more drugs at a time, they can keep HIV infection in check for long periods. **Antiretroviral drugs have reduced the death rate from HIV/AIDS by 80%**. At the same time, they have made dramatic improvements in the quality of life for people who have HIV infection.

At the same time, anti-retroviral drugs have side effects of their own and can cause interactions for other drugs that a person may need to take for opportunistic infections.

(d) Prevention of HIV and AIDS

While global prevalence of HIV infection (percentage of persons infected with HIV) appears to have stabilized in recent years, the global number of people living with HIV is increasing because of ongoing accumulation of new infections with longer survival times, measured over a continuously growing general population.

Across the world, a small but growing number of countries have reduced HIV prevalence through sound prevention efforts. The high rates of transmission of HIV result largely from failure to use the available and effective prevention strategies and tools, and poor coverage of HIV prevention programs. HIV prevention services were only reaching 20% of people in need in 2005, while coverage for key populations at higher risk of exposure to HIV were considerably lower.

Effective HIV prevention programming focuses on

- the critical relationships between the epidemiology of HIV infection
- the risk behaviors that expose to HIV transmission and
- addresses the collective social and institutional factors such as
 - sexual norms
 - gender inequality
 - and HIV related stigma, that will otherwise continue to fuel HIV epidemic

Risk behaviors are enmeshed in complex webs of

- economic
- legal
- political
- cultural and
- psychosocial determinants that must be analyzed and addressed by policies that are also effectively implemented, and through scaled-up programming

Comprehensive HIV prevention requires a combination of programmatic and policy actions that promote

- safer behaviors
- reduce vulnerability to transmission
- encourage use of key prevention technologies
- promote social norms that favor risk reduction and
- address drivers of the epidemic

Effective prevention efforts focus on measures that directly support risk reduction by providing information and skills as well as access to needed commodities (such as condoms, sterile injecting equipment, and drug substitution therapy) for the populations most in need. In short, national planners and policymakers must: 1) Know their epidemic; and 2) Set priorities accordingly.

Prevention and treatment must be scaled up in a balanced way, to capitalize fully on synergies between the two. Comprehensive HIV prevention requires a combination of programmatic interventions and policy actions that promote safer behaviors, reduce biological and social vulnerabilities to transmission, encourage use of key prevention technologies, and promote social norms that favor risk reduction.

HIV prevention includes addressing an array of issues discussed in other thematic areas in the policy section of the website. Forging links among HIV prevention with related programs and services such as sexual and reproductive health services and legal services for women, can also contribute to intensification of HIV prevention. Strong linkages as well as special efforts to reach those at higher risk and excluded from access to services will result in more relevant and cost-effective programs with greater impact.

Essential Policy Actions for HIV Prevention

1. Ensure that human rights are promoted, protected and respected and that measures are taken to eliminate discrimination and combat stigma.
2. Build and maintain leadership from all sections of society, including governments, affected communities, nongovernmental organizations, faith-based organizations, the education sector, media, the private sector and trade unions.
3. Involve people living with HIV, in the design, implementation and evaluation of prevention strategies, addressing the distinct prevention needs.
4. Address cultural norms and beliefs, recognizing both the key role they may play in supporting prevention efforts and the potential they have to fuel HIV transmission.
5. Promote gender equality and address gender norms and relations to reduce the vulnerability of women and girls, involving men and boys in this effort.
6. Promote widespread knowledge and awareness of how HIV is transmitted and how infection can be averted.
7. Promote the links between HIV prevention and sexual and reproductive health.

8. Support the mobilization of community-based responses throughout the continuum of prevention, care and treatment.

9. Promote programs targeted at HIV prevention needs of key affected groups and populations.

10. Mobilizing and strengthening financial, and human and institutional capacity across all sectors, particularly in health and education.

11. Review and reform legal frameworks to remove barriers to effective, evidence based HIV prevention, combat stigma and discrimination and protect the rights of people living with HIV or vulnerable or at risk to HIV.

12. Ensure that sufficient investments are made in the research and development of, and advocacy for, new prevention technologies.

Effective HIV prevention programming focuses on the critical relationships between the epidemiology of HIV infection, the risk factors that are known to be associated with the transmission of HIV and the structural and social factor, such as gender inequality and human rights violations, that drive the epidemic and impede peoples' abilities to access and use HIV information and services, making them vulnerable to HIV infection. HIV prevention is for life and must be sustained so that cumulative efforts address the HIV prevention needs of new cohorts of populations that may be vulnerable to HIV infection.

Sex workers, men who have sex with men, injecting drug users, and prisoners, tend to have a higher prevalence of HIV infection than that of the general population, because (i) they engage in behaviors that put them at higher risk of becoming infected and (ii) they are among the most marginalized and discriminated against populations in society.

In countries with low-level and concentrated epidemics, well-designed and adequately funded HIV prevention programs among these populations have proven decisive in slowing or even stopping the epidemic in its tracks. Countries with generalized epidemics that place a high priority on HIV programming for these populations, guided by epidemiological surveillance, will ensure the most effective use of resources.

Many other populations are also vulnerable to HIV and their HIV prevention needs should also be addressed. These key populations include:

- ✓ Children and Orphans
- ✓ Indigenous People
- ✓ People who inject drugs
- ✓ Men who have sex with men
- ✓ Migrants and mobile workers
- ✓ Peacekeepers
- ✓ People in the Health sector
- ✓ People in Prison settings
- ✓ Refugees and internally displaced people
- ✓ Sex workers and their clients
- ✓ Women and girls
- ✓ Young People

➤ **According to Medical Research:**

To keep from getting HIV:

- Use latex condoms. **Proper, consistent use of a latex condom can prevent transmission of HIV 80 to 95% of the time.** Condoms can also help reduce the risk of acquiring some other STDs.
- Use plastic wrap or dental dams to help prevent HIV-infection during oral and oral-anal sex.
- Use clean needles: if you do use injectable drugs, use a new, clean needle every time.
- Have sober sex. Drug and alcohol-free sex increases your chances of having safer sex.
- Learn more. The more you know about safe sex, your body, condom use, HIV/AIDS and your partner, the better you can protect yourself against sexually transmitted diseases.
- **Fewer partners, monogamy and abstinence.** The fewer sex partners you have, the more you reduce your risk of HIV infection. While sex is a healthy, natural part of life, you may want to wait to have sex until you know the person you are with is someone you truly care about and has your best interest in mind. If they're not willing to wait, then maybe they weren't worth the wait. Trust yourself and what you need. It's your life and your health. Protect it.

➤ **According to Medical Research:**

Proper, consistent use of a condom:

- Prevents transmission of **HIV** by 80-95%
- Prevents transmission of **HPV** by 70%
- Reduces the risk of **gonorrhea** in men by 70%
- Consistent use prevents the spread of HIV
- Reduces the risk of **syphilis**
- Reduces the risk of sexually transmitted infection during oral sex
- Reduces the risk of HPV, **herpes, Chlamydia, and pelvic inflammatory disease.**

➤ **Prevention:**

➤ **Female Condoms:**

Although shown to be effective in prevention of pregnancy and acceptable to users, the female condom has not achieved its full potential in national programs because of its relatively high cost. A new version of the Reality® female condom is made of synthetic nitrile, which makes it considerably less expensive. The new device has the potential for wider acceptability and utilization.

It is hoped that, if high utilization rates of the new device can be achieved, it will make a substantial contribution to prevention of unwanted pregnancy and sexually transmitted infections (STI), including HIV.

In addition to the new female condom, trials are also under way to test the effectiveness of diaphragms and other methods of protecting the cervix for HIV and STI prevention.

➤ **Male Circumcision:**

Male circumcision is one of the oldest and most common surgical procedures known. It is undertaken for cultural, religious, social as well as medical reasons.

The evidence that adult male circumcision is effective in reducing sexual transmission of HIV from women to men is compelling.

Male circumcision should always be considered as part of a comprehensive HIV prevention package. Moreover, wherever male circumcision services are offered, training and certification of providers, as well as careful monitoring and evaluation of programs, will be necessary to ensure that these meet their objectives and that quality services are provided safely, with adequate equipment and with appropriate counseling and other services.

➤ **New Prevention Technologies:**

New technologies, such as HIV preventive vaccines and microbicides, offer hope for sustained control of the HIV epidemic, particularly in the world's most vulnerable and marginalized populations.

Given the obstacles many women encounter when trying to negotiate the use of male condoms, there is an urgent need for more prevention options they can initiate themselves.

It is crucial to ensure that men and women will have access to new prevention technologies once they have been tested and proven safe and effective. To assure such access and prepare for the introduction of such technologies, issues related to financing, intellectual property right, manufacturing, procurement, logistics, delivery and provider and consumer education must be addressed. Once available, new prevention technologies will be additional prevention methods within comprehensive HIV prevention programming, but will not replace other effective means of reducing the risk of HIV infection.

Ensuring availability of safe and effective vaccines and microbicides will also demand appropriate regulatory approval and licensing infrastructure, manufacturing capacity and reasonably reliable in-country delivery networks. Even when these are in place, ensuring adoption will require end-user awareness about preventive products, effective pricing and financing mechanisms to ensure affordability, and a supportive social and policy environment.

➤ **Prevention of Mother to child:**

Prevention of HIV transmission from mother to her baby while in the womb or during birth or infant feeding requires a comprehensive package of services that includes preventing primary HIV infection in women, preventing unintended pregnancies in women living with HIV, preventing transmission from pregnant women living with HIV to their infants, and providing care, treatment and support for women living with HIV and their families.

Health systems need to be strengthened so that interventions to prevent mother to child transmission of HIV infection, including the use of antiretroviral drugs, can be safely and effectively implemented. Moreover, HIV testing in pregnancy has a number of benefits in terms of prevention and care for mother and child, although to avoid or minimize negative consequences testing must be voluntary and confidential and accompanied by quality counseling.

Timely administration of antiretroviral drugs to the HIV-diagnosed pregnant woman and her newborn significantly reduces the risk of mother-to-child HIV transmission. Positive mothers should also be provided with access to ART for the protection of their own health.

Combination regimes appear to be most effective but were until recently regarded as too costly for widespread use in low- and middle-income countries.

In recent years, projects to prevent mother-to-child transmission in resource-limited settings have primarily focused on provision of single-dose intrapartum and neonatal nevirapine, which cuts the risk of HIV transmission by more than 40%. While the benefits of single-dose nevirapine outweigh the risk of resistance in these settings, development of affordable regimens with superior resistance profiles is an urgent global priority.

(e) Attitudes towards HIV and AIDS

➤ Behavior:

Unlike some infectious diseases, transmission of HIV is mediated directly by human behavior, so changing behaviors that enable HIV transmission is the ultimate goal or outcome required for HIV prevention.

Sexual behavior, which remains the primary target of HIV prevention efforts worldwide, is widely diverse and deeply embedded in individual desires, social and cultural relationships, and environmental and economic processes. So too are the behaviors related to transmission through injecting drug use and from mother to child. This makes HIV prevention a complex task with multiple dimensions, that requires both policy and programmatic actions.

In the context of HIV, risk is defined as the probability that a person may acquire HIV infection. Certain behaviors create, enhance and perpetuate such risk.

Risk arises from individuals engaging in risk behaviors for a variety of reasons such as lack of information, inability to negotiate safer sex, unavailability of condoms, etc. Over the recent years, the approach to HIV has broadened to not only focus on individual risks but also on the environmental and social factors that influence such behavior, and the key role that power relationships and gender inequalities play in influencing risk (UNAIDS, 1998).

Despite recent evidence in expansion of access to prevention, treatment, care and support services, the fundamental role of human behavior in the continued spread of HIV is increasingly clear. Fostering health enhancing behavior change outcomes demands a persistent commitment to meeting the diverse and changing needs of individuals, and to addressing the characteristics of their social, cultural and physical environments that place them at risk.

➤ Communication for behavior change

- ➔ Information, Education and Communication – sometimes called IEC - are a critical part of the puzzle for achieving the goal of universal access to HIV prevention, treatment, care and support. However, information, education and communications must be combined with other interventions to succeed.
- ➔ Methods of communication range from one-to-one personal interactions to posters placed in school classrooms to prevention messages on national television. The focus may range from reducing stigma or decreasing HIV infection, but the ultimate goal is behavior change.
- ➔ National programs must identify the array of behavior change needs and communication strategies throughout the country. Resources can then be devoted to development of programming specific to each cultural or behavioral group at high risk of HIV infection.

- ➔ Whatever the local epidemiological and social conditions, effective HIV prevention programs prioritize and focus on the intervention needs of people most at risk of exposure to HIV and likely to engage in HIV risk behaviors, and they focus program efforts on reaching adequate numbers of these key audiences with good quality services. These audiences should be segmented, and information and services should be tailored to meet each subpopulation's needs.
- ➔ Segmenting in this sense means identifying subpopulations within each key audience that are different enough to require different approaches or messages (for example, distinguishing transgendered persons from men who have sex with men, or street-based from brothel-based sex workers). It does not mean singling out those populations for blame or persecution, or stigmatizing an HIV prevention measure as only for specified people. Effective HIV prevention includes efforts to ensure that segmenting the response does not lead to stigmatization and other unintended adverse consequences.

➤ **On a Personal Level:**

You don't necessarily have to tell someone your HIV status right away. You may want to see how a relationship unfolds. The closer a relationship gets and the more time that passes, the harder it can be to talk about it sometimes.

Whatever happens, accept the reaction. You can't control how others deal with the news. Their reaction isn't a reflection on you – it's a reflection of them.

You don't have to tell everyone. You can take time to think about what you want. As you consider telling others about your status, **you might want to think about:**

- Why do you want to tell them? Are you looking for something from them?
- **How can you tell them that might make it easier?** Would having articles, websites or hotlines to leave with the person you're telling be helpful to them?
- **How might they react to the news?** What would be the best scenario? The worst? **People can have a wide range of reactions to news like this.**
- How much do you want to tell them? Some people may ask how you came to be infected with HIV. It's up to you to decide how much you want to say.
- Getting support from others who have had to face similar situations.

➤ **On a Professional Level:**

One particularly tricky consideration is whether to tell an employer about your health status. **The Americans with Disabilities Act (ADA) protects people with disabilities from job discrimination. As long as you can do the essential functions of your job, your employer can't legally discriminate against you because of your HIV status.**

If your illness or treatment interferes with your job, you may want to tell your employer. Get a letter from your doctor explaining what you need to do for your health.

Talk to your boss or personnel director. Assure them that you want to continue working and what changes may be needed in your schedule or workload to do so. Make sure that they understand that you want to keep your HIV status confidential.

(f) Appropriate behavior in dealing with persons who may have the virus or syndrome

➤ Care & Support:

People living with HIV have a wide range of care and support needs. These include psychosocial support as well as treatment for 'opportunistic infections' (the illnesses to which they become vulnerable as the immune system is destroyed by the virus). When their HIV infection reaches the stage that it becomes life-threatening, they require treatment with antiretroviral drugs. However, the vast majority of people around the world do not yet have access to such services. Reaching out to them is a global priority.

AIDS-related care and support are key elements in the response to the epidemic: not only do they directly benefit people living with HIV, but they help also to reduce the social and economic impact of the epidemic and to boost HIV prevention.

Community care and support groups have sprung up almost everywhere in the world where the AIDS epidemic has appeared, and have shown amazing creativity and steadfastness in providing comfort and hope to people living with, or affected by, HIV.

The great majority of people with AIDS in low and middle-income countries are cared for at home, since health services are beyond the reach of large proportions of the population or are struggling to cope with the burden of the virus.

Home- and community-based care takes many forms, but typically it is provided by relatives, friends, or community volunteers working for non-governmental organizations and supported to a greater or lesser extent by health professionals, mainly nurses.

➤ Monitoring & Evaluating:

UNAIDS harmonizes monitoring and evaluation approaches at global, regional and country levels to generate reliable and timely information on the epidemic and the response.

The Country Response Information System (CRIS)

CRIS is an information system for monitoring and evaluating national responses to AIDS. It includes integrated indicator, project/resource tracking, and research modules. It facilitates the development of a clearinghouse for indicator data to enable indicator exchange between UN and other partner applications..

➤ Stigma & Discrimination:

Because of its association with behaviors that may be considered socially unacceptable by many people, HIV infection is widely stigmatized.

People living with the virus are frequently subject to discrimination and human rights abuses: many have been thrown out of jobs and homes, rejected by family and friends, and some have even been killed.

Together, stigma and discrimination constitute one of the greatest barriers to dealing effectively with the epidemic. They discourage governments from acknowledging or taking timely action against AIDS. They deter individuals from finding out about their HIV status. And they inhibit those who know they are infected from sharing their diagnosis and taking action to protect others and from seeking treatment and care for themselves.

➤ Workplace attitudes toward people living with HIV/AIDS, and acceptance of condom use and other preventive measures have increased in some countries as a result of HIV policies and practices, according to a report by the **International Labor Organization**, the U.N. News Service reports (*U.N. News Service*, 4/15). The report, titled "Saving Lives, Protecting Jobs," was prepared by the ILO Program on HIV/AIDS in the World of Work and presented to the U.S. Department of Labor, which is the funding partner in the Strategic HIV/AIDS Responses in Enterprises, or SHARE, project, Occupational Health Safety reports.

➤ **The report tracked changes in attitudes related to HIV/AIDS and looked at data collected from the ministries of labor, and employers and employees from workplaces** in six SHARE pilot countries, including Belize, Benin, Cambodia, Ghana, Guyana and Togo. According to the report, in all six countries, the proportion of workers who reported supportive attitudes toward co-workers living with HIV/AIDS increased on average from 49% in 2003 to 63% (*Occupational Health Safety*, 4/15). Attitudes toward condom use also improved in the six countries.

The percentage of workers who reported using condoms with nonregular partners increased from 74% in 2003 to 84%, the report found. The recorded changes in behavior could be attributed partly to the increased access to HIV services in the workplaces in all six countries, the report noted (*U.N. News Service*, 4/15). According to an ILO release, the report also found that in 2003 when SHARE started, only 14% of the participating workplaces in the six pilot countries had codified HIV policies. The report found that 76% of the participating enterprises now have written policies.

➤ 14 April 2008 - Article

Saving lives, protecting jobs: new horizons in the fight against HIV/AIDS at work

HIV is having a devastating effect on the world of work. The majority of the 33.2 million people worldwide living with HIV/AIDS are working and have skills and experience their families, workplace and countries can ill afford to lose. As the UN's lead agency in HIV/AIDS workplace interventions, the ILO is launching a new report highlighting strategic responses to HIV/AIDS in enterprises worldwide. ILO Online spoke with Dr Sophia Kisting, Director of the ILO/AIDS.

✓ The workplace offers distinct opportunities and advantages as a key delivery point for HIV prevention, treatment and care programs on an on-going basis. Using a combination of dialog, training and facilitation methods, the **SHARE** program aims to increase the capacity of government, employers' and workers' organizations in participating countries to protect working people from HIV and help to reduce its impact on the world of work. The main thrust of the SHARE program is action at the enterprise level.

The program financed by the United States Department of Labor is now reaching more than a million workers.

● **Is changing attitudes and behavior key to successful workplace interventions?**

Behavior change programs are an essential and central element in enterprise-level initiatives within SHARE. Many workers do not know enough about HIV to protect themselves, while others do know but still don't change their behavior to reduce the risk of infection.

Behavior change is a form of participatory education that encourages people to understand their own attitudes to HIV, assess their own risks, and motivate them to change behavior. The program uses targeted messages and approaches and is implemented through a system of peer education. This is based on the idea that individuals are most likely to change their behavior through the support of people they know and trust. **Positive individual behavior change in turn encourages and motivates more collective behavior change.**

Various Out Reach Programs

- Out of the Closet
- Men's Wellness Center
- West Hollywood Mobile Testing Unit
- Magic Johnson Mobile Testing Van
- Jails Testing Program
- Partner Counseling and Referral Services
- Social Marketing
- Outreach and Education
- Oakland
- InSpot

LESSON 2: Sanitation and Sterilization (4 hours)

(a) Universal Sanitation and Sterilization Precautions

Objectives:

- List precautionary elements that will protect the client
- Describe the proper progression of client services when using Foot Spas
- Explain proper cleaning and disinfection procedures for equipment

(b) How to distinguish between disinfectants and antiseptics

Objectives:

- Define the terms disinfectant and antiseptic
- Identify precautions with these chemicals
- List their purposes

(c) How to sanitize hands and disinfect tools used in the practice of Cosmetology and Body Wrapping

Objectives:

- Describe disease prevention
- Describe the recommended hand washing technique
- List ways to transmit pathogens
- List adverse effects of using hand sanitizers

(a) Universal Sanitation and Sterilization Precautions

The United States Environmental Protection Agency has set Universal Sanitation and Sterilization Rules.

One Universal Sanitation and Sterilization Precaution is the Recommended Cleaning and Disinfection Procedures for Foot Spa Basins in Salons

Preventing Pedicure Foot Spa Infections

Guidance from the EPA and the Centers for Disease Control and Prevention (CDC)

Outbreaks of skin infections on the legs and feet of patrons following spa pedicures have caused concern about spa safety. Information for customers of salon pedicure foot spas can help reduce the potential for infections associated with pedicure foot spa use.

Recommended Cleaning and Disinfection Procedures for Foot Spa Basins in Salons

Customer precautions - protecting the client

- **Check the condition of the client's feet and legs:** If open sores or skin wounds are present (including insect bites, scratches, scabbed-over wounds, or any condition that weakens the skin barrier), explain to the client why they should not use the foot bath.
- **Complete pedicure or wax after the foot bath soak:** Any procedure that risks damage to a client's skin should not be done before soaking feet in the foot spa basin.

Step by step instructions for disinfecting pedicure foot spa equipment

- **After Each Client:** (this can take place any time after the client's feet are out of the footbath, while feet are massaged, toes are painted, or other opportunities)
 - **Drain** the water from the foot spa basin or bowl and remove any visible debris.
 - **Clean** the surfaces of the foot spa with soap or detergent, rinse with clean water, and drain.
 - **After cleaning, disinfect*** the surfaces with an **EPA-registered hospital disinfectant** - according to the manufacturer's directions on the label. Surfaces must remain wet with the disinfectant for **10 minutes or the time stated on the label**, which may be shorter.
 - * **For whirlpool foot spas, air-jet basins, "pipe-less" foot spas, and other circulating spas:** It is best to disinfect by filling the basin with clean water, adding the appropriate amount of liquid disinfectant, and turning the unit on to **circulate** the disinfectant for the entire contact time.
 - After disinfection, **drain and rinse** with clean water.
- **Nightly:**
 - **For whirlpool foot spas, air-jet basins, "pipe-less" foot spas, and other circulating spas:**
 - **Remove** the filter screen, inlet jets, and all other removable parts from the basin and clean out any debris trapped behind or in them.

- Using a brush, **scrub** these parts with soap or disinfectant (following cleaning directions).
 - **Rinse** the removed parts with clean water and place them back into the basin apparatus.
 - **Fill** the basin with clean water and add an **EPA-registered hospital disinfectant**, following label directions. Turn the unit on and **circulate** the system with the liquid for 10 minutes, or the label-indicated time if different. (The whirlpool mechanism of the tub must be operating for the entire disinfection period so the piping and internal components that contain hidden bacteria are disinfected.)
 - **After disinfection, drain, rinse, and air dry.**
- **For simple basins (no circulation):**
- **Drain** the basin and remove any visible debris.
 - **Scrub** the bowl with a clean brush and soap or disinfectant (following cleaning directions). **Rinse and drain.**
 - **Disinfect** basin surfaces with and **EPA-registered hospital disinfectant**, following manufacturer's instructions. Surfaces must remain wet with the disinfectant for 10 minutes or the contact time stated on the label.
 - **Drain** the basin, **rinse** with clean water, and let air-dry.

Label information on disinfectant products

The label should clearly state that the product is a hospital or medical disinfectant. It may also list the following organisms:

Staphylococcus aureus

Salmonella enterica (formerly S. choleraesuis)

Pseudomonas aeruginosa

**The product label should clearly identify an EPA Registration Number.
The label will also specify use sites that are health care related.**

Important additional measures

- **Follow your state guidelines and regulations:** Some states require a weekly flush of the whirlpool mechanism with bleach and that the bleach remain in contact for over eight hours. Salons should consult state cosmetology regulations to make sure they are in compliance.
- **Read all labels and instruction manuals:** Always follow label directions for disinfectant products, and consult operating manuals for foot spa basins. Care should be taken to use appropriate doses of products to prevent damage to foot spas.
- **Know the condition of your equipment:** If your whirlpool foot spa has not been regularly cleaned and disinfected, you may need to do more than just the maintenance steps listed above to remove bacterial buildup from the system. Consult the foot spa manufacturer for further information. A higher level EPA-registered disinfectant, such as those labeled "Tuberculocides," may be used initially (refer to the listing of these products on the List. Once the system has been adequately disinfected, regular maintenance with cleaning and use of a hospital disinfectant, as described in this document, may be used.

Related information

Guideline for Cleaning and Disinfecting Manicuring and Enhancement Equipment

These guidelines outline procedures cleaning (sanitizing) and disinfecting all types of equipment used during manicuring and enhancement services including items such as manicuring bowls, pushers, nippers, clippers, abrasive files and buffers.

In the salon, all tools, implements, devices or other pieces of equipment must be properly cleaned and disinfected before it comes into direct contact with a client, as required by the licensing rules and regulations of your region, state or country.

Proper Cleaning and Disinfection

Just about everything in the salon has a hard or soft surface of some type. Some examples are manicuring tabletops and arm cushions, finger bowls, towels, files/buffers, implements, etc. Any of these surfaces coming into direct contact with a client's skin is considered "contaminated".

All contaminated surfaces must be thoroughly and properly:

1) cleaned and then 2) disinfected.

To be considered properly clean, a surface must first be thoroughly scrubbed free of all visible signs of debris or residue (contamination). Proper cleaning is the total removal of all visible residue from every surface of tables, tools and equipment, followed by a complete and thorough rinsing with clean water.

Proper cleaning (also called sanitizing) must be performed before continuing with the disinfection step. Proper disinfection is the destruction of potentially harmful or infection-causing microorganisms (pathogens) on a pre-cleaned surface.

Disposable (Single Use) items

Items that the manufacturer designs to be disposed of after one use are called "disposable" or "single-use". These items must be properly disposed of after one use on a single client. Reusing these items is considered an unsanitary, improper and unprofessional practice.

Some examples of disposable items are: cotton balls, gauze pads, wooden implements, disposable towels, toe separators, tissues, wooden sticks, arbor bands/ sleeves for electric files and certain abrasive files and buffers. Items damaged during the cleaning and disinfecting process are considered single-use and must be discarded after every client.

Proper Product Application

Some types of products can become contaminated if improperly used. Some examples are: creams, lotions, scrubs, paraffin wax, masks, and oils. These products must always be used in a sanitary manner that prevents contamination. For example, paraffin and nail oils should not be applied with a brush (or spatula) that has touched the skin. These practices may introduce bacteria into the product and cause contamination that can render products unsafe for use.

To avoid product contamination always:

- (a) Dispose of used or remaining product between clients.
- (b) Use **single-use disposable implements** to remove products from containers for application or remove product with a clean and disinfected spatula and put product to be used into a disposable or disinfect-able service cup.
- (c) Use an applicator bottle or dropper to apply the product.

Proper Disinfection of Multi-Use Tools and Equipment

Some items are designed to be used more than once and are considered to be “multi-use”. Multi-use items are sometimes referred to as “disinfect-able”, which means that the implement can be properly cleaned and disinfected while retaining its usefulness and quality. Multi-use items are designed for use on more than one client, but require proper cleaning and disinfection between each use. Examples of multi-use items include cloth towels, manicure bowls, nippers, pushers and certain abrasive files and buffers.

Multi-use items come in three varieties;

- 1) Hard and non-absorbent items constructed of hard materials that do not absorb liquid, i.e. metal, glass, fiberglass or plastic. These should be cleaned and disinfected as described below.
- 2) Porous and/or absorbent items constructed of materials such as cloth or wood with surfaces that may absorb or are penetrated by liquids, i.e. scrub brushes for nails, cushioned abrasive buffers, cloth towels and chamois. They should be cleaned and disinfected as described below.
- 3) Self-disinfecting items that will not support the growth of bacteria, viruses or fungi. Examples are application brushes used for nail polish, primers along with artificial enhancement application brushes. Due to the nature of these products, the brushes do not require disinfection and should be cleaned, used and stored only as recommended by the product manufacturer.

Individual Client Packs

Tools/instruments kept in individual packs must be properly cleaned and disinfected after each use. If a client provides their own implements/tools, they must be properly cleaned and disinfected before use. State rules require all tools and equipment to be disinfected before being reused, even if used by the same client! Improperly cleaned and disinfected implements may grow infection/disease-causing organisms before the client returns for their next visit, thereby increasing the risk of infection. Never use air-tight bags or containers for storage as these can promote bacterial growth.

Methods of Proper Cleaning

Proper cleaning requires liquid soap/detergent, water and the use of a clean and disinfected scrub brush to *remove all visible* debris and residue. All items should be scrubbed with a clean and disinfected scrub brush under running water. Cleaning is not disinfection; disinfection is an entirely separate step. Different items are cleaned in different ways. This often depends on what the item is made of and how it was used.

NOTE: the cleaning step must be properly performed before an item can be disinfected. All items must be thoroughly rinsed and dried with clean cloth or paper towels prior to putting them into a disinfectant.

Cleaning (sanitation) Method Examples

- Scrub Brush - Abrasive files, buffers, paddles
- Ultrasonic Cleaner - Metal pushers & nippers
- Acetone Soak -Metal electric file bits used on enhancements
- Washing machine -Cloth towels, linens, chamois
- Towelette/Wipe -Electrical equipment, table tops

Methods of Proper Disinfecting

After proper cleaning, all reusable implements/tools must be disinfected by complete immersion in an appropriate disinfecting solution.

The item must be completely immersed so that all surfaces, including handles, are soaked for the time required on the disinfectant manufacturer's label. In general, U.S. Environmental Protection Agency (EPA) registered disinfectants require 10 minute immersion; isopropyl and ethyl alcohol require 5 minutes.

Remove items after the required time, using clean and disinfected tongs or gloves to avoid skin contact with the disinfectant solution. If required by the instruction label, rinse thoroughly in running water.

Allow items to air dry completely by placing them on top of a clean towel and covering them with another clean towel. Thick foam cushioned buffers should have the moisture pressed out while in between clean towels to ensure the buffer is dry before storing in a sanitary manner.

It is recommended to spray 60-90% isopropyl or ethyl alcohol on clean, porous abrasives and buffers to disinfect them. A contact time of 5 minutes is sufficient for proper disinfection.

Methods for Proper Storage of Tools and Equipment.

All properly cleaned, disinfected and dried implements/ tools must be stored in a sanitary manner. A lined drawer is usually adequate, provided it is clean, contains only clean items and is properly labeled.

Store soiled or used items in a properly labeled, covered container separate from clean items. Never use airtight containers or zipper bags – these may promote bacterial growth!

Abrasive Files, Buffers and Electric File Bits

After each use abrasive files, buffers, blocks or bits must be thoroughly cleaned by manually brushing with a clean and disinfected brush or by other adequate methods to remove all visible debris. The sides of foam cushioned buffers, blocks or other abrasives should also be brushed after each use.

After proper cleaning abrasives files, buffers and blocks are best disinfected by immersing in (or saturating with) 70-90% isopropyl or ethyl alcohol for 5 minutes. Once electric bits have been thoroughly cleaned, they must be disinfected by complete immersion in an appropriate EPA registered disinfectant, as described in the next section. Any porous (absorbent) abrasive file, buffer, block, band, etc. that comes in contact with broken, damaged, infected or unhealthy skin or nails must be properly disposed of immediately, as described below.

Appropriate Disinfectants

How do you know if a disinfectant product is suitable for professional salon use? Standards and requirements vary

from country to country, but in the United States, the EPA registered Hospital disinfectants with bactericidal, fungicidal and virucidal claims on the label are best for use in salons. Some disinfectants are designed for use on hard- surfaces while others are best used on porous or absorbent items. EPA-registered Hospital disinfectants are good examples of a type that is suitable for hard surfaces.

Isopropyl alcohol and ethyl alcohol (70 – 90%) are suitable for porous/absorbent items. Disinfectant products are designed to destroy disease-causing microorganisms (pathogens) on non-living surfaces, such as those described in this document. They are not appropriate for use on living skin and contact with skin should be avoided.

Appropriate salon disinfectants include the following:

- (a) EPA-registered Hospital disinfectants with bactericidal, fungicidal and virucidal claims on the label.
- (b) 10% bleach solution (1 part bleach to 9 parts water)
- (c) Isopropyl alcohol, 70%-90% solution
- (d) Ethyl alcohol, 70%-90% solution

Contact with Blood, Body Fluid or Unhealthy Conditions

If blood or body fluid comes in contact with any salon surface, the nail professional should put on a pair of clean protective, disposable gloves and use an EPA-registered Hospital liquid disinfectant or a 10% bleach solution to clean up all visible blood or body fluid. In case of an accidental cut, clean with an antiseptic and bandage the cut.

Disposable items, such as a cotton-tipped wood stick must be immediately double-bagged and discarded after use, as described at the end of this section. Any non-porous instrument or implement that comes in contact with an unhealthy condition of the nail or skin, blood or body fluid, must be immediately and properly cleaned, then disinfected using an EPA-registered Hospital disinfectant as directed or a 10% bleach solution for 5 minutes.

Any porous/absorbent instrument that comes in contact with an unhealthy condition of the nail or skin, blood or body fluid must be immediately double-bagged and discarded in a closed trash container or bio-hazard box.

Some EPA disinfectants are registered for hospital use, but may not say “Hospital” on their label. In these cases, the product label MUST claim effectiveness against *Salmonella choleraesuis*, *Staphylococcus aureus*, and *Pseudomonas aeruginosa*.

Additional Information about Disinfectants and Cleaners

1) Disinfectants must be mixed, used, stored and disposed of according to manufacturer’s label instructions (proper mixing ratio is of the utmost importance to be an effective disinfectant). Some are ready to use and do not require mixing.

2) U.S. Federal Law prohibits the use of EPA-registered disinfectants in a manner that is contrary to its label.

- 3) Disinfectants must be prepared fresh every day (including spray bottles). Further, they must be replaced immediately if the solution becomes visibly contaminated. Disinfectant solutions will lose their strength upon standing and become ineffective within 24 hours. Use a logbook to record when fresh disinfectant is made.
- 4) Disinfectants are ineffective if implement/tools are not properly cleaned prior to use.
- 5) Just spraying disinfectants on tools and equipment is inadequate. Pre-cleaning is required before spraying the disinfectant and most types require ten minute contact to be effective.
- 6) Disinfectants can damage or rust some metal tools if improperly used.
- 7) All disinfectant containers must be properly labeled. Disinfectant solutions prepared in the salon must list on the container: the contents and percentage solution (concentration), and use a logbook to record the date and time of mixing. Check the label for the product's expiration date.
- 8) All brushes used for cleaning purposes, i.e., nail brushes and electric-file bit cleaning brushes, must be properly cleaned and disinfected between each use.
- 9) Ultra-violet light cabinets are not suitable replacements for liquid disinfectant solutions. These can be used for storage after properly cleaning and disinfecting implements/tools with a liquid solution.
- 10) Read all warning labels and precisely follow manufacturer's instructions.

These guidelines are believed to be highly effective and are designed to help avoid unforeseen pitfalls, problems and complications.

These guidelines are not a replacement for local government standards, rules or regulations.

Always consult federal, state and local laws and regulations, which may vary somewhat from these recommendations.

Protect Your Skin!

- Microorganisms in foot spas can enter through the skin; so broken skin (e.g., cuts and abrasions) should not come into contact with foot spa water.
- Do not shave, use hair removal creams, or wax your legs during the 24 hours before receiving treatment in a foot spa.
- Do not use a foot spa if your skin has any open wounds such as bug bites, bruises, scratches, cuts, scabs, poison ivy, etc.

Identifying an Infection

Open wounds appear on the skin of feet and legs. Initially they may look like insect bites, but they increase in size and severity over time, and sometimes result in pus and scarring.

Cause of Infections

Some incidents of foot spa infections have been caused by *Mycobacterium fortuitum*. This organism can occur naturally in water and soil. Other organisms have also been found in footbath systems. The screens and tubes of foot spas are particularly good places for the bacteria to collect and grow, often forming dense layers of cells and proteins called biofilms, which can be very hard to remove.

Know how the salon cleans and disinfects foot spas.

- Ask salon workers how the foot spas are maintained and how often.
- A foot spa should be disinfected between each customer, and nightly. The disinfectant needs to work for the full time listed on its label, typically 10 minutes, depending on the type of disinfectant.
- Proper cleaning and disinfection can greatly reduce the risk of getting an infection by reducing the bacteria that can build up in the foot spa system.

Disinfectants used in the foot spa should indicate on the label that they're approved for hospital use.

A disinfectant label should clearly show its uses and that it is EPA-approved.

- Salons should use an EPA-registered hospital disinfectant
- The label (at right) should list relevant product information, including:
 - The terms "Disinfectant" and also "Hospital" or "Medical" or "Health Care". This indicates the product can be used as a disinfectant on surfaces in these environments.
 - The EPA registration number.
 - Some products may have instructions for both sanitizing and disinfecting footbaths. **Pedicurists should follow disinfecting directions.**

Do not use the foot spa if you are not sure it is disinfected and safe to use. Do not risk your health. You should report any problems to your state cosmetological board.

(b) How to distinguish between disinfectants and antiseptics

Disinfectants and Antiseptics

Antiseptic: A substance that inhibits the growth and reproduction of disease-causing microorganisms. For practical purposes, antiseptics are routinely thought of as topical agents, for application to skin, mucous membranes, and inanimate objects.

Disinfectant: Any chemical agent used chiefly on inanimate objects to destroy or inhibit the growth of harmful organisms.

Purpose

Antiseptics are a diverse class of drugs which are applied to skin surfaces or mucous membranes for their anti-infective effects. Their uses include cleansing of skin and wound surfaces after injury, preparation of skin surfaces prior to injections or surgical procedures, and routine disinfection of the oral cavity as part of a program oral hygiene.

Antiseptics are also used for disinfection of inanimate objects, including instruments and furniture surfaces.

Commonly used **antiseptics for skin** cleaning include benzalkonium chloride, chlorhexidine, hexachlorophine, iodine compounds, mercury compounds, **alcohol and hydrogen peroxide**. Other agents which have been used for this purpose, but have largely been supplanted by more effective or safer agents, include boric acid and volatile oils such as methyl salicylate.

Chlorhexidine shows a high margin of safety when applied to mucous membranes, and has been used in oral rinses and preoperative total body washes.

Benzalkonium chloride and hexachlorophine are used primarily as hand scrubs or face washes. Benzalkonium may also find application as a disinfecting agent for instruments, and in low concentration as a preservative for drugs including ophthalmic solutions. Benzalkonium chloride is inactivated by organic compounds, including soap, and must not be applied to areas which have not been fully rinsed.

Iodine compounds include tincture of iodine and povidone iodine compounds. Iodine compounds have the broadest spectrum of all topical anti-infectives, with action against bacteria, fungi, viruses, spores, protozoa, and yeasts.

Iodine tincture is highly effective, but its alcoholic component is drying and extremely irritating when applied to abraded (scraped or rubbed) skin. Povidone iodine, an organic compound, is less irritating and less toxic, but not as effective.

Povidone iodine has been used for hand scrubs and disinfection of surgical sites. Aqueous solutions of iodine have also been used as antiseptic agents, but are less effective than alcoholic solutions and less convenient to use than the povidone iodine compounds.

Hydrogen peroxide acts through the liberation of oxygen gas. Although the antibacterial activity of hydrogen peroxide is relatively weak, the liberation of oxygen bubbles produces an effervescent action, which may be useful for wound cleansing through removal of tissue debris.

The activity of hydrogen peroxide may be reduced by the presence of blood and pus. The appropriate concentration of hydrogen peroxide for antiseptic use is 3%, although higher concentrations are available.

Thimerosal (Mersol) is a mercury compound with activity against bacteria and yeasts. Prolonged use may result in mercury toxicity.

Precautions

Precautions vary with individual product and use. Consult individualized references.

Hypersensitivity reactions should be considered with organic compounds such as chlorhexidine, benzalkonium and hexachlorophene.

Skin dryness and irritation should be considered with all products, but particularly with those containing alcohol.

Systemic toxicity may result from ingestion of iodine containing compounds or mercury compounds.

Iodine compounds should be used sparingly during pregnancy and lactation due to risk of infant absorption of iodine with alterations in thyroid function.

Alcohols

Alcohols have been appreciated for centuries for their antiseptic qualities. As a chemical group, alcohols possess many features that are desirable for an antiseptic. They have a bactericidal action against vegetative cells. They are relatively inexpensive, usually easily obtainable, and relatively nontoxic with topical application.

Alcohols have a cleansing action, evaporate readily, and are colorless. Their destructive action against spores is much less effective than that against vegetative cells. The greatest amount of work has been done with ethanol.

Phenols

Crude mixtures of cresols (krē'sôl', -sôl', -sôl') solubilized by soap or alkali were originally introduced as **Lysol** and are still used as rough disinfectants. They need to be applied at high concentrations, are irritant, and toxic, but they kill bacteria, fungi, and some viruses.

For **more refined applications as antiseptics**, chlorinated cresols or xylenols are commonly used in practice. These compounds are less active than cationic antiseptics against Staphylococci and Pseudomonas.

Hexachlorophene is a different kind of phenolic antiseptic that acts slowly, but binds strongly to the skin. It was used widely in surgical soaps and antiperspirant preparations. However, absorption through the skin can cause damage to the central nervous system, particularly in infants, and the use of **hexachlorophene is now severely restricted.**

Phenol no longer plays a significant role as an antibacterial agent, although its use has not been abandoned entirely. Phenols are still used today in drug formulations such as **cold-sore creams and liquids, throat lozenges**, and washes. **Phenol derivatives are also used as preservatives and antimicrobial agents in germicidal soaps and lotions.**

Quaternary Ammonium Compounds

Initially, Quaternary Ammonium Compounds were used as an adjunct to surgery, such as in preoperative patient skin treatment, de-germing the hands of the surgical team pre-operatively, and **disinfection of surgical instruments.**

(c) How to sanitize hands and disinfect tools used in the practice of Cosmetology and Body Wrapping

Hand Washing

Hand washing, when done correctly, is the single most effective way to prevent the spread of communicable diseases. Good hand washing technique is easy to learn and can significantly reduce the spread of infectious diseases among both children and adults.

What types of disease can good hand washing prevent?

- Diseases spread through fecal-oral transmission. Infections which may be transmitted through this route include salmonellosis, shigellosis, hepatitis A, giardiasis, enterovirus, amebiasis, and campylobacteriosis. Because these diseases are spread through the ingestion of even the tiniest particles of fecal material, hand washing after using the toilet cannot be over-emphasized.
- Diseases spread through indirect contact with respiratory secretions. Microorganisms which may be transmitted through this route include influenza, Streptococcus, respiratory syncytial virus (RSV) and the common cold. Because these diseases may be spread indirectly by hands contaminated by respiratory discharges of infected people, illness may be avoided by washing hands after coughing or sneezing and after shaking hands with an individual who has been coughing and sneezing.
- Diseases may also be spread when hands are contaminated with urine, saliva or other moist body substances. Microorganisms which may be transmitted by one or more of these body substances include cytomegalovirus, typhoid, staphylococcal organisms, and Epstein-barr virus. These germs may be transmitted from person to person or indirectly by contamination of food or inanimate objects such as toys.
-

What is good hand washing technique?

There is more to hand washing than you think! By rubbing your hands vigorously with soapy water, you pull the dirt and the oily soils free from your skin. The soap lather suspends both the dirt and germs trapped inside and are then quickly washed away.

Follow these four simple steps to keeping hands clean:

- 1) Wet your hands with warm running water.
- 2) Add soap, then rub your hands together, making a soapy lather. Do this away from the running water for at least 15 seconds, being careful not to wash the lather away. Wash the front and back of your hands, as well as between your fingers and under your nails.
- 3) Rinse your hands well under warm running water. Let the water run back into the sink, not down to your elbows.
- 4) Dry hands thoroughly with a clean towel. Then turn off the water with a clean paper towel and dispose in a proper receptacle.

What type of soap should be used?

Any type of soap may be used. However, bar soap should be kept in a self draining holder that is cleaned thoroughly before new bars are put out and liquid soap containers (which must be used in day care centers) should be used until empty and cleaned before refilling. To prevent chapping use a mild soap with warm water; pat rather than rub hands dry; and apply lotion liberally and frequently.

May I use the over-the-counter alcohol gels for washing my hands instead of using soap and water?

These products, which can be found wherever soap is sold, are very effective at killing germs on the hands as long as your hands are not visibly dirty. They should be used when soap and water are not readily available.

To use correctly, apply about a teaspoonful of the alcohol gel on the palm of one hand. Then rub all over both hands, making sure you rub the front, back, and fingernail areas of both hands. Let the alcohol dry, which should take about 30 seconds.

If your hands look dirty but you have no other way to wash your hands, use the gel but wash with soap and water as soon as you can.

The History of Hand Washing

The history of hand washing began in the Health Care Sector and has had a profound effect on the Personal Service and Beauty Industry.

For generations, hand washing with soap and water has been considered a measure of personal hygiene. The concept of cleansing hands with an **antiseptic agent** probably emerged in the early 19th century. As early as **1822**, a French pharmacist demonstrated that solutions containing chlorides of lime or soda could eradicate the foul odors associated with human corpses and that such solutions could be used as disinfectants and antiseptics.

In **1846**, Ignaz Semmelweis observed that women whose babies were delivered by students and physicians in the First Clinic at the General Hospital of Vienna consistently had a higher mortality rate than those whose babies were delivered by midwives in the Second Clinic. He noted that physicians who went directly from the autopsy suite to the obstetrics ward had a disagreeable odor on their hands despite washing their hands with soap and water upon entering the obstetrics clinic. He proposed that the puerperal fever that affected so many of these women was caused by "cadaverous particles" transmitted from the autopsy suite to the obstetrics ward via the hands of students and physicians.

Perhaps because of the known deodorizing effect of chlorine compounds, as of May **1847**, he insisted that students and physicians clean their hands with a chlorine solution between each patient in the clinic.

The maternal mortality rate in the First Clinic subsequently dropped dramatically and remained low for years. This intervention by Semmelweis represents the first evidence indicating that cleansing heavily contaminated hands with an **antiseptic agent** between patient contacts may reduce health-care--associated **transmission of contagious diseases** more effectively than hand washing with plain soap and water.

In **1961**, the U. S. **Public Health Service** produced a training film that demonstrated hand washing techniques recommended for use by health-care workers. At the time, recommendations directed that personnel wash their hands with soap and water for 1--2 minutes before and after patient contact.

Rinsing hands with an antiseptic agent was believed to be less effective than hand washing and was recommended only in emergencies or in areas where sinks were unavailable.

Center for Disease Control.

In **1975 and 1985**, formal written guidelines on hand washing practices were published by the **Center for Disease Control**. These guidelines recommended hand washing with non-antimicrobial soap between services to patrons. Use of waterless antiseptic agents (alcohol-based solutions) was recommended only in situations where sinks were not available.

In **1988 and 1995**, guidelines for hand washing and hand antisepsis were published by the **Association for Professionals in Infection Control**. Recommended indications for hand washing were similar to those listed in the CDC guidelines.

The **1995 APIC** guideline included more detailed discussion of alcohol-based hand rubs and supported their use in more public settings than had been recommended in earlier guidelines.

In **1995 and 1996**, the **Healthcare Infection Control Practices Advisory Committee** recommended that either antimicrobial soap or a waterless antiseptic agent be used. These guidelines also provided recommendations for **hand washing and hand antisepsis** in other public settings.

Transmission of Pathogens on Hands

Transmission of pathogens from one person to another happens when:

- Organisms present on the patron's skin transfers to the hands of the Salon Professional
- Hand washing or hand antisepsis by the Salon Professional are inadequate or omitted entirely, or the agent used for hand hygiene is inappropriate.
- The contaminated hands of the Salon Professional comes in direct contact with another person, or with an inanimate object that will come into direct contact with a person

Pathogens can be transported from one person to another. The number of organisms present on the skin varies.

Persons with diabetes, patients undergoing dialysis for chronic renal failure, and those with chronic dermatitis are more likely to have colonized organisms. We shed microorganisms daily from normal skin onto nightgowns, bed linen, bedside furniture, and other objects in our environment.

Scientific Study of Hand Washing

Investigators use different methods to study hand washing, antiseptic hand wash, and surgical hand antisepsis protocols.

Differences among the various studies include:

- whether hands are purposely contaminated with bacteria before use of test agents,
- the method used to contaminate fingers or hands,
- the volume of hand-hygiene product applied to the hands,
- the time the product is in contact with the skin,
- the method used to recover bacteria from the skin after the test solution has been used, and
- the method of expressing the effectiveness of the product

Despite these differences, the majority of studies can be placed into one of two major categories:

- studies focusing on products to remove transient flora and
- studies involving products that are used to remove resident flora from the hands

The majority of studies of products for removing transient flora from the hands involve artificial contamination of the volunteer's skin with a defined test organism before the volunteer uses a plain soap, an antimicrobial soap, or a waterless antiseptic agent.

In the United States, antiseptic hand wash products are regulated by FDA's Division of Over-the-Counter Drug Products (OTC).

Products are evaluated by using a standardized method. Tests are performed in accordance with use directions for the test material.

Plain (Non-Antimicrobial) Soap

Soaps are detergent-based products that contain esterified fatty acids and sodium or potassium hydroxide. They are available in various forms including bar soap, tissue, leaflet, and liquid preparations. Their cleaning activity can be attributed to their detergent properties, which result in removal of dirt, soil, and various organic substances from the hands.

Plain soaps have minimal, if any, antimicrobial activity. However, hand washing with plain soap can remove loosely adherent transient flora. For example, hand washing with plain soap and water for 15 seconds reduces bacterial counts on the skin by 0.6--1.1, whereas washing for 30 seconds reduces counts by 1.8--2.8.

Alcohols

The majority of alcohol-based hand antiseptics contain either isopropanol, ethanol, n-propanol, or a combination of two of these products.

The majority of studies of alcohols have evaluated individual alcohols in varying concentrations. Other studies have focused on combinations of two alcohols or alcohol solutions containing limited amounts of hexachlorophene, quaternary ammonium compounds, povidone-iodine, triclosan, or chlorhexidine gluconate.

Alcohols, when used in concentrations present in alcohol-based hand rubs, also have activity against several viruses.

For example, 70% isopropanol and 70% ethanol are more effective than medicated soap or nonmedicated soap in reducing viruses on fingers. Products containing 60% ethanol were also found to reduce the presence of viruses.

Other viruses such as hepatitis A and the polio virus may require 70%--80% alcohol to be reliably inactivated. However, both 70% ethanol and a 62% ethanol foam product with emollients reduced hepatitis A virus on whole hands or fingertips more than nonmedicated soap.

Both were equally as effective as antimicrobial soap containing 4% chlorhexidine gluconate in reducing reduced viral counts on hands. In the same study, both 70% ethanol and the 62% ethanol foam product demonstrated greater virucidal activity against polio virus than either non-antimicrobial soap or a 4% chlorhexidine gluconate-containing soap.

However, depending on the alcohol concentration, the amount of time that hands are exposed to the alcohol, and viral variant, alcohol may not be effective against hepatitis A and other viruses. Alcohol can prevent the transfer some pathogens.

Alcohol-based products are more effective for standard hand washing than soap or antimicrobial soaps.

The effectiveness of alcohol-based hand-hygiene products is affected by several factors, including:

- the type of alcohol used,
- concentration of alcohol,
- contact time,
- volume of alcohol used, and
- whether the hands are wet when the alcohol is applied.

Frequent use of alcohol-based formulations for hand antisepsis can cause drying of the skin unless emollients, humectants, or other skin-conditioning agents are added to the formulations. The drying effect of alcohol can be reduced or eliminated by adding 1%--3% glycerol or other skin-conditioning agents.

Moreover, in several recent prospective trials, alcohol-based rinses or gels containing emollients caused substantially less skin irritation and dryness than the soaps or antimicrobial detergents tested. These studies, which were conducted in clinical settings, used various subjective and objective methods for assessing skin irritation and dryness. Further studies are warranted to establish whether products with different formulations yield similar results.

Alcohols are flammable. As a result, alcohol-based hand rubs should be stored away from high temperatures or flames in accordance with National Fire Protection Agency recommendations.

Chlorhexidine

Chlorhexidine was developed in England in the early 1950s and was introduced into the United States in the 1970s.

It has antimicrobial activity. Chlorhexidine's immediate antimicrobial activity occurs more slowly than that of alcohols. Chlorhexidine has good activity against some bacteria, somewhat less activity against other bacteria and fungi. It has activity against some viruses such as herpes simplex virus, HIV, and influenza.

Chloroxylenol

Chloroxylenol is a phenolic compound that has been used as a preservative in cosmetics and other products and as an active agent in antimicrobial soaps. It was developed in Europe in the late 1920s and has been used in the United States since the 1950s.

The antimicrobial activity of PCMX is attributable to inactivation of bacterial enzymes and alteration of cell walls. It has good activity against certain organisms and fair activity against some bacteria, and certain viruses.

Hexachlorophene

In the 1950s and early 1960s, emulsions containing 3% hexachlorophene were widely used for hygienic hand washing, as surgical scrubs, and for routine bathing of infants in hospital nurseries. The antimicrobial activity of hexachlorophene results from its ability to inactivate essential enzyme systems in microorganisms.

Studies of hexachlorophene as a hygienic hand wash and surgical scrub demonstrated only modest efficacy after a single hand wash. Hexachlorophene has residual activity for several hours after use and gradually reduces bacterial counts on hands after multiple uses. It has a cumulative effect. With repeated use of 3% hexachlorophene preparations, the drug is absorbed through the skin.

Iodine and Iodophors

Iodine has been recognized as an effective antiseptic since the 1800s. However, because iodine often causes irritation and discoloring of skin, iodophors have largely replaced iodine as the active ingredient in antiseptics.

Iodine molecules rapidly penetrate the cell wall of microorganisms and inactivate cells by forming complexes with amino acids and unsaturated fatty acids, resulting in impaired protein synthesis and alteration of cell membranes.

The majority of iodophor preparations used for hand hygiene contain 7.5%--10% povidone-iodine. Formulations with lower concentrations also have good antimicrobial activity because dilution can increase free iodine concentrations. However, as the amount of free iodine increases, the degree of skin irritation also may increase.

Quaternary Ammonium Compounds Quaternary ammonium compounds are the most widely used as antiseptics.

Quaternary ammonium compounds are primarily bacteriostatic and fungistatic, although they are microbicidal against certain organisms at high concentrations.

In the United States, these compounds have been seldom used for hand antisepsis during the last 15--20 years. However, newer hand washing products containing benzalkonium chloride or benzethonium chloride have recently been introduced for use.

A recent study of surgical intensive-care unit personnel found that cleaning hands with antimicrobial wipes containing a quaternary ammonium compound was about as effective as using plain soap and water for hand washing; both were less effective than decontaminating hands with an alcohol-based hand rub. One laboratory-based study reported that an alcohol-free hand-rub product containing a quaternary ammonium compound was effective in reducing microbial counts on the hands of volunteers.

Triclosan

Triclosan is a nonionic, colorless substance that was developed in the 1960s. It has been incorporated into soaps and into other consumer products. Concentrations of 0.2%--2% have antimicrobial activity. Triclosan has a broad range of antimicrobial activity. It is classified as safe and effective for use as an antiseptic hand wash.

Other Agents

Certain other agents are being evaluated by FDA for use in health-care-related antiseptics. However, the effectiveness of these agents has not been evaluated adequately for use in hand washing preparations.

Irritant Contact Dermatitis Resulting from Hand-Hygiene Measures

Frequency of Irritant Contact Dermatitis

Frequent and repeated use of hand-hygiene products, particularly soaps and other detergents, is a primary cause of chronic irritant contact dermatitis.

This is of great concern to Cosmetologists and all Salon Professionals in the Personal Service Industry.

The potential of detergents to cause skin irritation can vary considerably. Irritation associated with antimicrobial soaps may be caused by the antimicrobial agent or by other ingredients of the formulation. Affected persons often complain of a feeling of dryness or burning; skin that feels rough or even scaling.

Detergents can damage the skin. Irritant contact dermatitis is more commonly reported with iodophors. Other antiseptic agents that can cause irritant contact dermatitis (in order of decreasing frequency) include chlorhexidine, triclosan, and alcohol-based products.

Skin that is damaged by repeated exposure to detergents may be more susceptible to irritation by alcohol-based preparations.

Allergic Contact Dermatitis Associated with Hand-Hygiene Products

Allergic reactions to products applied to the skin may present as delayed type reactions or less commonly as immediate reactions. The most common causes of contact allergies are fragrances and preservatives; emulsifiers are less common causes. Liquid soaps, hand lotions or creams, and may contain ingredients that cause contact allergies.

Allergic reactions to antiseptic agents, including quaternary ammonium compounds, iodine or iodophors, chlorhexidine, triclosan, and alcohols have been reported. Allergic contact dermatitis associated with alcohol-based hand rubs is uncommon.

Allergic reactions to alcohol-based products may represent true allergy to alcohol, allergy to an impurity or aldehyde metabolite, or allergy to another constituent of the product.

Allergic contact dermatitis or immediate contact reactions may be caused by ethanol or isopropanol.

Allergic reactions can be caused by compounds that may be present as inactive ingredients in alcohol-based hand rubs, including fragrances, benzyl alcohol, stearyl or isostearyl alcohol, phenoxyethanol, myristyl alcohol, propylene glycol, parabens, and benzalkonium chloride.

Proposed Methods for Reducing Adverse Effects of Agents

Potential strategies for minimizing hand-hygiene--related irritant contact dermatitis include reducing the frequency of exposure to irritating agents (particularly detergents), replacing products with high irritation potential with preparations that cause less damage to the skin, and increasing education on hand care.

Hand lotions and creams often contain humectants and various fats and oils that can increase skin hydration and replace altered or depleted skin lipids that contribute to the barrier function of normal skin.

MRSA Methicillin-Resistant Staphylococcus Aureus

An outbreak of “USA300 strain” **MRSA: methicillin-resistant Staphylococcus aureus** occurred in a Cosmetologist and 2 of her customers.

Eight other persons, who were either infected or colonized, were linked to this outbreak, including a family member, a household contact, and partners of customers.

The CA-MRSA USA300 strain is known to cause outbreaks among population groups, such as:

- native Americans,
- prison inmates,
- military personnel,
- men who have sex with men, and
- competitive sports participants,
- and accounts for 97% of MRSA isolates obtained in emergency departments across the United States from patients with soft tissue infections.

CA-MRSA is associated with invasive infections. The USA300 strain, which is also found in Europe was first isolated in the Netherlands in 2002.

Overall prevalence of MRSA in the Netherlands is low (2%). In 2006, 3.8% of all MRSA isolates sent to the National Institute for Public Health were identified as the USA300 strain.

We report an outbreak of the USA300 strain related to a Beauty Salon in the Netherlands, in a:

- Cosmetologist
- A family member
- A household contact and
- Customers and their partners.

The Study of MRSA

In September **2005**, a medical microbiologist from the regional medical microbiology laboratory **reported** to the municipal health department a **recurring MRSA infection in a Cosmetologist**. From **December 2004** onwards, the woman had recurrent infections on the:

- ✓ legs,
- ✓ buttocks, and
- ✓ groin

resulting in treatment to include incision and drainage of lesions. When an abscess developed in the genital area in **July 2005**, MRSA was cultured from a wound swab.

In **December 2005**, the Cosmetologist was declared MRSA-free after antimicrobial treatment.

Swabs were taken 3 times in 1-week intervals from:

- nose,
- throat,
- perineum, and
- wound

and used for enrichment culture of MRSA. In **March 2006**, the woman was tested again for MRSA colonization; test results showed that she had been reinfected or that therapy had failed. The Cosmetologist had eczema. Because of the "hands on" nature of her work, she was advised to temporarily stop providing services to customers.

The municipal health department conducted a risk assessment of the woman's household contacts and the Beauty Salon. **The Netherlands does not require that MRSA infections be reported**. Therefore, the municipal health department depends upon the consent and full cooperation of index patients and contacts for further investigation of outbreaks. Consequently, in this instance, household contacts for screening were identified but had not presented themselves for screening. Contacts who had complaints sought treatment at the emergency department, where the observant infection control practitioner and microbiologists related them to the MRSA outbreak.

Nurses obtained specimens by swabbing each patient's nose, throat, and wounds. A case was defined as a patient who had a culture-confirmed MRSA infection during the outbreak period July 2005–December 2006 and a direct epidemiologic link to the index patient.

In April 2006, a **salon customer** was hospitalized with an **abscess of the breast caused by MRSA**; in July 2006, **another customer** who had had **boils** since February 2006 was found to be **MRSA positive**.

Both customers had been given wax treatments by the Cosmetologist during the period in which she had an infected hair follicle in her armpit.

Swabs taken from this site showed that the beautician was infected with the same MRSA strain as before. Concern arose about the risk for infection to customers through:

- instruments,
- materials (wax), or
- contact with other employees.

The index patient and the other 6 employees of the salon regularly provided services to each another. A nurse and a member of the municipal health department visited the salon in June 2006 to check on hygiene protocols and to advise on preventive measures to reduce risk for further transmission. All working procedures and protocols were investigated, and the salon was advised to clean and disinfect instruments and procedure rooms. More specifically, the health department observed a total waxing procedure performed by the staff.

Ten swabs were taken from:

- used wax,
- wax implements, and
- the treatment room.

All 6 employees were screened and informed about MRSA and the current situation. Arrangements were also made to test 22 regular customers who had received wax treatments by the index patient in the previous 2 months. In the following weeks, these customers were screened at the municipal health office and informed about MRSA. Of the 22 regular customers, 21 completed a questionnaire and 19 were actually screened for MRSA by culturing samples from nose and throats.

All employees and the 19 selected regular customers were negative for MRSA colonization. All environmental swabs were also negative for MRSA. It was noted that the 70% alcohol used to disinfect the skin after waxing was diluted with water because customers had complained about the stinging effect of the alcohol on treated skin. Furthermore, it became apparent that after performing waxing treatments the Cosmetologist would touch the waxed skin of customers with ungloved hands to check for remaining hairs. She did not wash her hands after removing the gloves.

During the outbreak investigation, more background information became available from those who were MRSA colonized or infected and who could be indirectly linked to the beautician or her customers. During the week that the first infected customer was identified (in April 2006), another customer was hospitalized with an abscess in the groin. Unfortunately, no culture was taken from this patient. The partner of the second infected customer was also infected with MRSA that was related to an abscess on his leg.

By the end of 2006, a MRSA-positive couple was identified as a contact of the second infected customer. In August 2006 another couple was reported to be MRSA positive; both had abscesses on the thighs. Because no further epidemiologic data could be obtained, whether the couple's infection was linked to the beauty salon is not clear.

A total of 45 persons who had been in direct or indirect contact with the beautician were screened for MRSA:

- 3 family members
- 3 roommates
- 11 other persons (including secondary contacts)
- 6 beauty salon employees and
- 22 customers (including regular customers)

Fifteen persons had skin infections and 10 of them were colonized with MRSA

- Cosmetologist
- family member
- roommate
- ex-partner of the roommate
- customers and
- partners of customers

Although skin infections never developed in the Cosmetologist's family members, tests did show MRSA colonization in one of them. The beautician's boyfriend, a native of the United States, had already lived for 2 years in the Netherlands.

Although he had skin lesions, no MRSA was found. The girlfriend of a sport mate who regularly exercised with the partner of a customer was colonized with MRSA at the end of 2006.

She had immigrated recently from the United States to the Netherlands, but her first screening test results were negative. The mean age of the patients was 29 years (range 21–40 years).

Eleven people were found to be MRSA positive.

Of these 11:

- 3 persons with a direct link to the beauty salon (the Cosmetologist and 2 customers)
- 6 with an indirect link (family member, roommate, ex-partner of roommate, partner of a customer, sport mate of partner of a customer and his partner), and
- a couple from whom no epidemiologic data could be obtained were infected with the same MRSA strain as the Cosmetologist.

All MRSA isolates were identical and identified as the well-known CA-MRSA USA300 strain.

All MRSA isolates had identical susceptibility patterns: resistant to oxacillin (and thus to all β -lactam antimicrobial drugs) and erythromycin, and susceptible to rifampicin, ciprofloxacin, gentamicin, clindamycin, vancomycin, teicoplanin, tetracycline, cotrimoxazole, mupirocin, and fusidic acid.

Conclusions

Outbreaks of CA-MRSA strains have been reported with increased frequency. Several reports involved outbreaks among:

- competitive sports participants
- military personnel
- men who have sex with men
- prisoners
- native Americans
- and drug users

Skin treatments in a beauty salon likely led to MRSA transmission as a result of contact with an infected Cosmetologist. Unless outbreaks occur in a defined group, MRSA remains undetected in the general population because reporting is not mandatory. Although the prevalence of MRSA in the Netherlands is low, local microbiologic laboratories should report outbreaks, when detected, to the local municipal health department for further investigation. More research is necessary to better understand the risk factors involved in these outbreaks.

LESSON 3: Diseases and Disorders of the Skin (4 hours)

Objectives:

- List purposes of the skin
- Describe the composition of skin
- List the layers of the skin
- Explain structural attributes of the skin
- Explain skin functions
- Describe the different types of bacteria
- Identify types of infections
- List classifications of parasites
- Explain bloodborne infections
- List descriptive terms for disease
- Name conditions of the skin
- Explain pigment disorders
- Identify factors that effect skin health
- Describe terms relating to disorders

Our level of health is often seen in the appearance of the skin. Environmental elements, hormonal imbalances, and stress can also change the skin's appearance.

Understanding the structure and function of skin can help in help in maintaining it's good health. Skin is our body's protective covering.

Our skin is varied with types and colorings from person to person. The skin, in a healthy state is very resilient and self-healing. It renews itself in the outer layer every 30 days.

It is the **largest organ** of the body and is just a few millimeters thick. Its layers **has many functions** and activities primarily as a protective covering for our muscles, tendons, bones and organs.

It keeps our internal workings intact, acts as a **barrier to bacteria** and foreign bodies and **secretes** natural waste through sweat.

Together the **sweat** and the **sebum** combine on the skin's surface to form the **barrier-like acid mantle**. A vital **regulator of temperature**, skin acts as our cooling system. We flush when we're hot because blood vessels near the skin's surface dilate to allow more warm blood to circulate closer to the air to cool.

When we're cold and need to conserve warmth, the blood vessels contract, so that a pale appearance is produced. **Sense of touch** is due to nerve endings in the **dermis**. They are the reactors of **heat, cold touch, pressure and pain**.

The skin is not abundantly absorbent as only small amounts of water or oil-soluble substances can penetrate. **Ultra-violet radiation can penetrate for the good as in the case of producing vital Vitamin D** and for the bad, as with unsafe sun exposure.

■ **Composition of the Skin**

The skin has layers running from the outer epidermis, the dermis and the sub layers of connective tissue.

The skin is made up of three distinct layers. The top layer is called the **epidermis**.

The word epidermis, and the name of the other main skin layer, the **dermis**, both come from the name used by the ancient Greeks for the skin, derma.

From this we also get the word **dermatologist**, meaning a doctor who **specialize** in skin problems.

The epidermis is translucent. It allows light to pass partially through it similar to frosted glass.

The **epidermis does not contain any blood vessels** but gets its oxygen and nutrients from the deeper layers of the skin. At the bottom of the epidermis is a very thin membrane, called the basement membrane, which attaches the epidermis to the layer below.

The second layer lies deeper and is called the **dermis**. It contains blood vessels, nerves, hair roots and sweat glands.

Below the dermis lies a layer of fat, the **subcutaneous fat**. The depth of this layer differs from one person to another. It contains larger blood vessels and nerves, and is made up of clumps of fat-filled cells called adipose cells.

The subcutaneous fat lies on the muscles and bones and **whole skin structure is attached by connective tissues**. The attachment is loose, so the skin can move fairly freely.

If the subcutaneous tissues fill up with too much fat the skin cannot move as easily and this is what creates cellulite.

Networks of tiny blood vessels run through the epidermis bringing food, vitamins and oxygen. In pale people, these vessels can be seen through the epidermis, particularly if the veins widen otherwise known as broken veins.

If the blood carries plenty of oxygen it will be pink and the skin will tend to have a rosy color. If the blood is running sluggishly and has lost most of its oxygen the skin will look bluer. These blood vessels respond to temperature changes.

They open up in hot weather, bringing lots of red blood cells - and hence a pink flush to the skin, and close down in the cold; this is why cold skin often looks blue.

In most areas of the body the epidermis is only 35-50 micrometers thick. A micrometer is one-millionth of a meter, one-thousandth of a millimeter. On the palms and the soles it is usually much thicker, up to several millimeters.

Deep within, new skin cells are continuously formed to replace the constant shedding of surface cells.

The outermost layer is made up of a flexible protein **keratin**.

It is constantly being shed and replaced by the new cells.

New skin cells are nourished by the dermis and if nutrient starved, will be poorly formed. However, if they have been fed from the start, the skin will be smooth, and hydrated.

It is important to remove make-up daily so that skin cells can flake off without oil and cosmetics clogging the process.

At the same time, the skin's pH between 4.5 and 6 needs to be preserved and not stripped with harsh, dehydrating products.

The thickest, innermost section of the skin is the dual layered **dermis**, home to several vital structures. A mesh of **twin proteins, collagen and elastin** fibers give skin its contours and elasticity. As we age these deteriorate.

The sebaceous glands, nerve endings, hair follicles and essential blood vessels all co-exist. **Sebum** secreted from the **sebaceous glands** lubricates the skin and is slightly acidic in content. It is also somewhat anti-bacterial.

Hormonal activity controls the amount of oil that the glands produce.
Should **oil** from the pores be overly plentiful, greasy skin and potential eruptions could result.

If oil is low the skin will be dry and possibly scaly.
The third layer of skin is a connective tissue dividing the dermis from the muscular layer.

■ **Functions of the skin**

Absorption	Substances can enter the body through the skin.
Excretion	Sweat glands within the skin puts out perspiration.
Heat regulation	Skin maintains our 98.6 °F body temperature.
Protection	Skin protects us from bacteria and viruses.
Secretion	Sebum is created by the sebaceous glands within the skin.
Sensation	Feeling cold, heat, pain and pressure.

Some of these functions are so important that **unless most of the skin is working efficiently**, we will die. This is the reason why second or third degree burns are so serious.

When the skin is destroyed over a large area, there is no way of controlling the rate at which **water is lost** to the outside environment, or of **regulating the temperature** of the body or of **controlling infection**.

Someone who has lost over half their skin this way is unlikely to survive.

Although we think of the skin as a single organ, the epidermis and dermis have, to some extent, separate functions.

The function of water conservation is however dependent on both; the role of the stratum corneum in this field is absolutely vital, as it acts as a semipermeable barrier and allows us to survive in a hostile environment.

The epidermis has three principal functions:

- protecting the body from the environment,
particularly the sun
- preventing excessive water loss from the body
- protecting the body from infection.

Epidermis is made up of:

- stratum corneum (horny layer)
- keratinocytes (squamous cells)
- basal layer

Dermis: The dermis is the middle layer of the skin.

- blood vessels
- lymph vessels
- hair follicles
- sweat glands
- collagen bundles
- fibroblasts
- nerves

Subcutis: The subcutis is the deepest layer of skin. The subcutis consists of a network of collagen and fat cells. It helps conserve the body's heat and protects the body from injury.

■ Environmental Impact on the Skin

The sun produces enormous amounts of heat and light, some of which reaches the earth. Without this heat and light there would be no life.

Unfortunately the sun also produces less beneficial rays, which are completely invisible to us, called **ultraviolet radiation**.

Part of this radiation is reflected by the stratum corneum at the skin surface, **part is absorbed** by the melanin in the epidermal cells, and **some is scattered** within the skin.

All three processes contribute to the vital function of protecting the nuclei of the cells in the epidermis and the collagen of the dermis.

This scattered radiation creates a lot of high-energy particles, which are called free radicals.

Free radicals are very reactive, and attack the constituents of the skin: this is why over a long time ultraviolet radiation produces so much damage.

Sunlight reflected from snow can damage our skin because it contains a substantial proportion of ultraviolet radiation.

Sunburn

The following are the most common symptoms of a sunburn. However, each individual may experience symptoms differently. Symptoms may include:

- redness
- swelling of the skin
- pain

- blisters
- fever
- chills
- weakness
- dry, itching, and peeling skin days after the burn

Water and the skin

Throughout our lives our bodies naturally lose water by constant gentle evaporation through our skins trans-epidermal water loss, although we are unaware of the process.

Preventing excessive water loss is exceptionally important. In the normal epidermis the water content gets less the closer we get to the surface.

Water makes up to 70-75% of the weight of the basal layer, but only 10-15% of the stratum corneum. The stratum corneum is a particularly important barrier to the control of moisture loss.

Cell Regeneration

With **increasing age**, the skin's cell renewal process becomes less efficient.

Tissue **repair** and cell **regeneration** slow down.

The amount of natural moisture present in the skin is reduced.

Because collagen production is less, the skin becomes thinner and loses its flexibility.

■ Protecting the skin

The most obvious sign of aging is a **decrease in the overall thickness of the epidermis** as a whole, with a reduction in the number of cell layers.

The number of cells in the stratum corneum does not diminish with age, however; this is important, because of the vital role of this layer as the skin barrier.

On the other hand, the numbers of melanocytes and other cells do decrease with age. Metabolism in the skin slows down. So does the rate at which epidermal cells are produced, which may interfere with wound healing.

The time necessary to repair the stratum corneum barrier increases considerably with age: the replacement of skin cells takes about twice as long for people over 75 as for those around 30.

Although the sebaceous glands themselves do not change much with increasing age, **sebum production declines** in many older people, especially after the age of 70.

With age, the number of active sweat glands falls and their output of **sweat decreases** too. As a result, perspiration is less in elderly skin. This explains why older people often find it hard to adapt to hot weather.

Most older people have dry skin and therefore have a special need to avoid the over-use of harsh soaps and detergents, in order to prevent problems associated with dryness.

Aged skin retains its fundamental ability to control water loss, but may partially lose this ability if the stratum corneum barrier becomes damaged by physical or chemical agents. Many substances will penetrate aged skin more easily than young skin.

As we grow older, the skin loses its firmness and elasticity. Patches of discoloration and areas of dilated blood vessels appear. On exposed areas of aged skin, such as the hands and face, the skin patterns are often markedly changed.

Reasons for the changing appearance:

- * blood circulation slows down
- * metabolism slows down
- * chemical changes take place in the tissues
- * sebaceous glands diminish in size and number
- * collagen production breaks down
- * hormone production is altered or reduced.

■ **Bacteriology and The Skin**

Germ Science

Bacteriology is the scientific study of bacteria, especially bacteria that cause disease.

Historically, bacteria have been the cause of some of the most deadly diseases and widespread epidemics of human civilization.

Bacterial diseases such as tuberculosis, typhus, plague, diphtheria, typhoid fever, cholera, dysentery, and pneumonia have killed many people.

Water purification, vaccinations and antibiotic treatment have reduced the death rate caused by bacterial diseases.

The Importance of Germ Science

An essential part of preventing the spread of infection in the community and at home is proper hygiene. This includes hand-washing and cleaning shared items and surfaces.

Antibacterial-containing products have not been proven to prevent the spread of infection better than products that do not contain antibacterial chemicals.

Although a link between antibacterial chemicals used in personal cleaning products and bacterial resistance has been shown in studies, no human health consequence has been demonstrated.

Microorganisms are the most fundamental, diverse, and prevalent biological organisms that inhabit the earth today.

Non Pathogenic Bacteria

The Definition of Non pathogenic: Incapable of causing disease.

Non pathogenic bacteria are harmless. Non pathogenic means not bringing disease into being.

Pathogenic

Bacteria that cause disease are called pathogenic bacteria. Bacteria can cause diseases in humans, in animals, and also in plants.

Some bacteria can only make one particular host ill; others cause trouble in a number of hosts, depending on the host specificity of the bacteria.

The diseases caused by bacteria are almost as diverse as the bugs themselves and include food poisoning, toothache, and certain forms of cancer.

Clinical bacteria are classified according to how dangerous they are. Pathogens are always likely to cause disease. Organisms which cause disease only when they have a special opportunity to gain entrance inside the body are called opportunistic.

Some organisms such as the Streptococcus can gain entry into the bloodstream and quietly become entrenched on the mitral valves of the heart causing a problem after a long period of time.

Some pathogens pro-actively create portals of entry. These organisms are called invasive, as for example, Salmonella or strains of Streptococcus, like the "flesh eating" bacteria.

When an infectious disease spreads and the cases of new infections reach a certain number, it is called an epidemic. Some epidemics become wide-spread and quickly reach distant parts of the world. We travel often times fast and frequent and bacteria can travel with us.

If a certain disease is always present in low numbers of cases in a given area, that disease is said to be endemic in that area.

■ Growth

Clinical bacteria are categorized based on whether they require strict anaerobic conditions for growth.

If they do, they are called anaerobes. If they do not, the term facultative is generally used.

Facultative means: having the capacity to live under more than one specific set of environmental conditions.

A plant that can lead either a parasitic or a nonparasitic life and a bacterium that can live with or without air, for example, E coli.

Very few organisms strictly require aerobic conditions for growth.

So, in most cases, an organism is said to be a facultative organism. Anaerobes account for 5-10% of all clinical infections.

Viruses

Most infections are caused by two main types of germs - bacteria and viruses.

Bacteria are organisms found almost anywhere, except normally sterile sites, such as the blood stream and spinal fluid.

Viruses are organisms that cause disease by invading healthy host cells. As virus particles multiply, the host cells burst, allowing the viruses to infect other cells.

Antibiotics kill bacteria, not viruses. Antibiotics will not cure upper respiratory viral illnesses, such as: colds or flu, most coughs and bronchitis, sore throats not caused by strep, or runny noses.

Taking antibiotics for viral infections - such as a cold, cough, the flu and most bronchitis - will not: cure the infections, keep other individuals from catching the illness, or help a person feel better.

Influenza is a viral infection of the lungs characterized by fever, cough, and severe muscle aches. In the elderly, it is a major cause of disability and death often as a result of secondary infection of the lungs by bacteria.

Even in the young and healthy, influenza produces a disease of a few days duration.

Influenza was responsible for the most devastating plague in human history. It was the the Spanish Flu.

It swept around the world in 1918 killing 675,000 people in the U.S. and an estimated 20–50 million people worldwide.

No one at the time even knew what disease agent was causing the pandemic. Not until 1930 in pigs and 1933 in humans was it established that influenza is caused by a virus.

There are three types of influenza:

Influenza C - Common but seldom causes disease symptoms.

Influenza B - Often causes sporadic outbreaks of illness, especially in residential communities like nursing homes.

Influenza A - Responsible for regular outbreaks. Influenza A viruses also infect domestic animals (pigs, horses, chickens, ducks) and some wild birds.

■ Parasites

A parasite is an organism that lives on or in a host.

There are three main classes of parasites that can cause disease in humans:

Protozoa

Helminths and Ectoparasites

Protozoa

are **microscopic, one-celled organisms** that can be free-living or parasitic in nature. They are able to multiply in humans and also permits serious infections to develop from just a single organism.

Helminths

are large, multicellular organisms that are generally visible to the naked eye in their adult stages. Like protozoa, helminths can be either free-living or parasitic in nature.

Ectoparasites:

Although the term ectoparasites can broadly include blood-sucking arthropods such as mosquitoes, this term is generally used more narrowly to refer to organisms such as ticks, fleas, lice, and mites that attach or burrow into the skin.

Parasitic Infections

Parasitic infections cause a tremendous burden of disease in both the tropics and subtropics as well as in more temperate climates.

Malaria, carried by mosquitoes, causes the most deaths globally from parasitic diseases and is estimated to kill over 800,000 children in sub-Saharan Africa annually.

Blood-borne Parasites

Some parasites can be blood-borne. This means two things:

- The parasite sometimes can be found in the blood stream of infected people; and
- The parasite might be spread to other people through exposure to an infected person's blood, for example, by blood transfusion or by sharing needles or syringes contaminated with blood.

Non Pathogenic

What are non pathogenic? Intestinal Amebae is one example.

Some parasites that are commonly found in people's intestines and stool specimens never make them sick.

Germ that don't cause illness are called non pathogenic. These parasites do not harm the body, even in people with weak immune systems.

You can become infected by swallowing something, such as food or water, or touching something and then putting your fingers in your mouth that was contaminated with stool from an infected person.

■ Protected by the Skin

The epidermis, particularly the stratum corneum - the outer most keratinized skin layer, provides a passive defense against entry of opportunistic infecting organisms and also performs an active role in immunity through immunological surveillance.

In short, the skin acts as a barrier and is the primary organ through which we interact with the external world.

Hair provides protection against heat loss by adjustment of hair density through contraction of the arrector pili muscle attached to each hair follicle.

By "fluffing up", the hair layer air can be held adjacent to the skin to provide a heat trapping, invisible layer.

Hair also helps with protection forming a tough barrier helping protect the epidermis from minor abrasions and/or from ultra violet light.

Hair such as eyebrows and eyelashes protect the eyes by channeling or sweeping away fluids, dust and debris.

Nasal hair plays an important role in trapping air borne foreign particles before reaching the lungs.

Hair also increases the surface area for faster evaporation of sweat from neighboring glands and individual hairs can aid sensory function.

Diseases and Conditions of the Skin

Bacteria and viruses can invade through an injury or opening of the skin.

The skin is made up of natural occurring barriers that protect us from undesirable environmental elements from entering our body

All areas of the skin contain nerves which are sensory receptors.
Without these receptors we could not feel heat, cold pressure or pain.

■ **Descriptive Terms and Definitions: In reference to diseases and conditions**

Acute	Severe symptoms.
Allergy	Physical reaction by the skin due to exposure to a substance.
Chronic	Recurring and long duration of symptoms
Contagious	Communicable
Dermatologist	Physician who specializes in the medical practice of the skin
Dermatology	The study, analysis and treatment of skin.
Diagnosis	Recognition of a disease by its symptoms
Disease	The pathological interference of the normal function of the body or it's parts
Disorder	An abnormal condition that is usually not contagious
Epidemic	Wide spread disease that affects a large number of people
Etiology	The study of the causes of diseases
Immune	When the body is totally resistant to a certain disease.
Immunity	Refers to the body's level and ability to be resistant to disease.
Infectious	The ability of a bacteria to enter the body
Inflammation	A skin disorder characterized by redness, pain, edema, and heat.
Occupational	Due to the activity of your job, possibly repetitive.
Parasitic	The type of any condition caused by animal or vegetable parasites.
Pathogenic	Any disease whose origin is bacterial
Pathology	The study of disease .
Prognosis	The predetermination, using educated insight, of the probable course of a disease.
Seasonal	Effects due to the exposure of changes in weather occurring throughout the year.
Subjective symptom	A symptom that can be felt but not seen

In a salon, you will assuredly come in contact with **diseases and disorders of the scalp**. You are responsible for being able to recognize infectious diseases and conditions that should be referred to a physician.

■ **Conditions of the skin**

Albinism	Congenital condition in which there is an absence of melanin pigment.
Chloasma	Patches of increased deposits of pigment in the skin are also known as liver spots.
Leucoderma	Light patches on the skin due to congenital defective pigmentations.
Naevus	A birthmark also known as portwine or strawberry that can be small or large and that includes the malformation of skin due to pigmentation or dilated capillaries.
Lentigo	Small spots that can be yellow to brown in color.
Vitiligo	The type of condition of leucoderma that can affect skin or hair.

Skin Pigment Disorders

Skin color is determined by a pigment, melanin made by specialized cells in the skin, melanocytes. The amount and type of melanin determines a person's skin color.

Melanin gives color to the skin, hair, and iris of the eyes. Levels of melanin depend on race and amount of sunlight exposure.

Sun exposure increases melanin production - to protect the skin against harmful ultraviolet rays. In addition, hormonal changes can affect melanin production.

Color changes of the skin and discoloration including shades of red, brown, purple and black are danger signs. Skin thickening can also be a sign of danger and should be examined by a physician.

Vitiligo

Vitiligo is a disorder in which white patches of skin appear on different parts of the body. This happens because the cells that make pigment, in the skin are destroyed. These cells are called melanocytes.

Vitiligo can also affect the mucous membranes such as the tissue inside the mouth and nose and the eye.

The cause is not known. Vitiligo may be an autoimmune disease. These diseases happen when your immune system mistakenly attacks some part of your own body.

In vitiligo, the immune system may destroy the melanocytes in the skin. It is also possible that one or more genes may make a person more likely to get the disorder.

Some researchers think that the melanocytes destroy themselves. Others think that a single event such as sunburn or emotional distress can cause vitiligo. But these events have not been proven to cause vitiligo.

In the United States, 2 to 5 million people have the disorder. Most people with vitiligo develop it before the age of 40.

The disorder affects all races and both sexes equally. People with certain autoimmune diseases (such as thyroid disease) are more likely to get vitiligo than people who don't have any autoimmune diseases.

Scientists do not know why vitiligo is connected with these diseases. Vitiligo may also run in families. Children whose parents have the disorder are more likely to develop vitiligo.

White patches on the skin are the main sign of vitiligo. These patches are more common in areas where the skin is **exposed to the sun**. The patches may be on the hands, feet, arms, face, **scalp**, and lips.

Those with dark skin may notice a loss of color inside their mouths. There is no way to tell if vitiligo will spread. For some people, the white patches do not spread.

For some people, vitiligo spreads slowly, over many years. For other people, spreading occurs quickly. Some people have reported more white patches after physical or emotional stress.

■ **Hypertrophies (excessive growth)**

Keratoma	The callus. It is the superficial, round, thickening of the epidermis caused by friction. If it grows inward it is called a corn.
Mole	A small spot on the skin that can be flat or raised. It is sometimes genetically inherited and it's colors can range from tan to brown or bluish black.
Polyp	A growth on the body that sometimes extends from the surface of the skin and others within the skin.
Skin Tag	A bead-like fibrous tissue that protrudes from the surface of the skin and is sometimes a dark color
Verruca	A wart, a viral infection of the epidermis and non cancerous.

Moles

According to recent research, certain moles are at higher risk for changing into cancerous growths, including malignant melanoma, a form of skin cancer.

Moles that are present at birth and atypical moles have a greater chance of becoming malignant. Recognizing changes in your moles is crucial in detecting malignant melanoma, and other cancerous skin growths at its earliest stage of development.

Warts

Warts are non-cancerous skin growths caused by the papillomavirus. Warts are more common in children than adults, although they can develop at any age.

Warts can spread to other parts of the body and to other persons.

There are many different types of warts, due to many different papillomavirus types, more than 100.

Warts are not painful, except when located on the feet. Most warts go away, without treatment, over an extended period of time.

Common types of warts:

common warts	Located around the nails and the back of the hands, rough surfaced, grayish-yellow or brown in color
foot warts	located on the soles of feet (plantar warts) with black dots (clotted blood vessels that once fed them); clusters of plantar warts are called mosaic; can be painful
flat warts	small, smooth growths that grow in groups up to 100 at a time; most often appear on children's faces
filiform warts	small, long, narrow growths that usually appear on eyelids, face, or neck

■ Inflammations of the skin

Eczema	Dry or moist lesions accompanied by itching and burning that usually has red-blisters and oozing.
Psoriasis	Lesions that are often round and are dry. Occurring in patches, they are covered with coarse, silvery scales. When irritated, they bleed. Although it spreads on the patient, it is not contagious.

Psoriasis

Psoriasis is a chronic skin condition characterized by inflamed, red, raised areas that often develop as **silvery scales on the scalp**, elbows, knees, and lower back.

Psoriasis is estimated to affect between 5 million to 7 million people in the US.

The cause of psoriasis is unknown, however, it is thought to be caused by abnormally fast-growing and shedding skin cells.

The skin cells multiply quickly causing the skin to shed every three to four days. Though not contagious, the condition is hereditary. Psoriasis is often recurrent and occurs in varying severity.

Types and symptoms of Psoriasis

Individual will experience symptoms differently, as psoriasis comes in several forms and severities.

➤ **discoïd psoriasis**

Also called **plaque psoriasis**, this type of psoriasis is the most common. Symptoms may include **patches of red, raised skin** on the trunk, arms, legs, knees, elbows, and **scalp**. Nails may also thicken, become pitted, and separate from the nail beds.

➤ **guttate psoriasis**

This type of psoriasis affects mostly children. Symptoms may include many small patches of red, raised skin. A sore throat usually precedes the onset of this type of psoriasis.

➤ **pustular psoriasis**

Symptoms may include small pustules (pus-containing blisters) all over the body or just on the palms, soles, and other small areas.

■ **Allergy Related Dermatitis**

Dermatitis Medicamentosa	Dermatitis that occurs after an medical injection.
Dermatitis Venenata	Allergy to ingredients in cosmetics.
Urticaria	Hives and inflammation caused by an allergy to specific drugs or foods.

Contact Dermatitis

Contact dermatitis is a physiological reaction that occurs after skin comes in contact with certain substances. The majority of these reactions are caused by irritants to the skin.

The remaining reactions are caused by allergens, which trigger an allergic response. In allergic reactions, the reaction may not start until after several days.

Contact dermatitis caused by an irritant that is not an allergic response occurs from direct contact with the irritant.

Adults are most commonly affected by allergic contact dermatitis, but it can affect persons of all ages.

Causes

The most common causes of allergic contact dermatitis in adults include the following:

- soaps /shampoos
- different foods
- detergents
- perfumes

Plants, as well as metals, cosmetics, and medications may also cause a contact dermatitis reaction:

- **poison ivy**
Poison ivy, which is part of a plant family that includes poison oak and sumac, is the most common cause of a contact dermatitis reaction
- **metals**
Nearly 3,000 chemical agents are capable of causing allergic contact dermatitis. Nickel, chrome, and mercury are the most common metals that cause contact dermatitis
- **cosmetics**
Many types of cosmetics can cause allergic contact dermatitis. **Permanent hair dyes** that contain paraphenylenediamine are the most frequent causes. Other products that may cause problems include dyes used in clothing, perfumes, eye shadow, nail polish, lipstick, and some sunscreens
- **medications**
Neomycin, which is found in antibiotic creams, is the most common cause of medication contact dermatitis. Penicillin, sulfa medications, and local anesthetics, such as novocaine or paraben, are other possible causes.

Symptoms of contact dermatitis

- mild redness and swelling of the skin
- blistering of the skin
- itching
- scaling and temporary thickening of skin

Skin lesions

Bulla	A blister containing body fluids.
Crust	Scab
Excoriation	An abrasion caused by injury such as a scraped knee.
Fissure	A crack in the skin that penetrates the dermal layer.
Macule	A small, discolored spot or patch on the skin's surface. A freckle is a good example of a macule
Scale	The accumulation of flakes of the epidermal layer.
Ulcer	Open lesions on the skin or mucous membranes.
Vesicle	A blister that contains body fluid within or just beneath the epidermis, an example is poison ivy.
Wheal	An itchy, swollen lesion that is temporary, for example: a mosquito bite.

■ Contagious disorders of the skin

Fungal infections of the skin

Skin fungi live in the dead, top layer of skin cells in moist areas of the body, such as the scalp.

These fungal infections cause only a small amount of irritation.

Other types of fungal infections penetrate deeper and may cause itching, swelling, blistering, and scaling.

In some cases, fungal infections can cause reactions elsewhere on the body. For example, a person may develop a rash on the scalp after touching an infected foot.

There are many types of fungal skin infections that require clinical care by a physician or other healthcare professional.

Tinea infections: Ringworm

"Ringworm" is a misleading term that refers to the circular appearance of the fungal lesion. There are no worms involved.

Different fungi, depending on their location on the body, cause ringworm.

Ringworm is characterized by ring-shaped, red, scaly patches with clearing centers.

Tinea is ringworm caused by **fungus**, a vegetable parasite, that includes symptoms of scaling of the skin.

It can affect the **skin of the scalp, face or neck**.

There is an increased risk of contracting ringworm if a person:

- is malnourished
- has poor hygiene
- lives in a warm climate
- has contact with other persons or pets that have ringworm
- is immunocompromised by disease or medication

Body ringworm (tinea corporis)

This skin infection is characterized by a ring-like rash anywhere on the body or the **face**.

It occurs in all ages, but is seen more frequently in children. It is more common in warmer climates.

The symptoms of body ringworm may include:

- red, circular lesion with raised edges
- the middle of the lesion may become less red as the lesion grows
- itching of the affected area

The lesions of ringworm are unique, and usually allow for a diagnosis simply on physical examination. Because the fungi can live indefinitely on the skin, recurrences of ringworm are likely.

■ Skin cancers

Basal Cell Carcinoma	The least serious type of skin cancer, containing light or pearly nodules with visible blood vessels.
Malignant Melanoma	The most serious type of skin cancer, containing dark brown, black, or discolored patches on the skin.
Squamous Cell Carcinoma	Scaly, red papules.
Tumor	Abnormal growth of swollen tissue.

At risk

Skin cancer is more common in fair-skinned people - especially those with blond or red hair, who have light-colored eyes.

Skin cancer is rare in children.

Almost half of all Americans who live to age 65 will be diagnosed with skin cancer at some point in their lives, according to the National Cancer Institute.

Other risk factors include the following:

- family history of melanoma
- sun exposure
- early childhood sunburns
- many freckles
- many ordinary moles (more than 50)

■ Disorders of the Sebaceous Glands

Acne Rosacea	The chronic inflammatory congestion of the cheeks and nose
Acne Simplex	The chronic inflammatory disorder that usually related to hormonal changes and overactive sebaceous glands
Acne Vulgaris	Acne pimples
Comedones	Blackheads, keratinized cells and hardened sebum
Cysts	Round, body fluid filled sac within the dermis caused by a ruptured follicle
Furuncle	A boil, which is a subcutaneous abscess that fills with pus
Milia	Whiteheads, which is an accumulation of dead, keratinized cells and sebaceous matter trapped beneath the skin's surface
Pimples	A follicle filled with oil, dead cells, bacteria and pus
Seborrhea	Oily Dandruff

■ Acne Scars

Acne Pit Scar	Sunken appearance, caused by pimples or cysts
Raised Scar	Lump of raised tissue on the surface of the skin, caused where cysts have clumped together
Ice Pick Scar	Large, open pore appearance, as if scarred with an ice pick, caused by deep pimples or cysts

Acne is a disorder of the hair follicles and sebaceous glands.

The glands become clogged, leading to pimples and cysts.

Acne is very common - nearly 17 million people in the US are affected by this condition.

Acne most often begins in puberty. During puberty, the male hormones, androgens, increase in both boys and girls, causing the sebaceous glands to become more active - resulting in increased production of oil - sebum.

The sebaceous glands produce sebum that normally travels via hair follicles to the skin surface. However, skin cells can plug the follicles, blocking the sebum coming from the sebaceous glands.

When follicles become plugged, skin bacteria begin to grow inside the follicles, causing inflammation. Eventually, the plugged follicle bursts, spilling oil, skin cells, and bacteria onto the skin surface.

In turn, the skin becomes irritated and pimples or lesions begin to develop. Acne can be superficial or deep.

Acne can occur anywhere on the body. However, acne most often appears in areas where there is a high concentration of sebaceous glands, including the following:

- face
- chest
- upper back
- shoulders
- neck

The following are the most common symptoms of acne. However, each individual may experience symptoms differently.

Symptoms may include:

- blackheads
- whiteheads
- pus-filled lesions that may be painful
- nodules (solid, raised bumps)

Hair Follicle of the Skin

The follicle is where a hair is formed. The follicle is an epidermal cavity within the dermis .

The Biological Formation of Hair

In the basal layer of the epithelial tissue cells multiply and create a bud-like structure.

Under this bud, connective cells clump together; these cells will be the origin of the dermal papilla and the connective tissue sheath.

The epithelial bud pushes down into the connective tissue.

On this epithelial column, two bulges appear: one will become the sebaceous gland, while the other will be the point at which the arrector muscle will be inserted.

This column meets the dermal papilla and attaches itself to it almost entirely surrounding it, itself being enclosed within the connective tissue sheath which has developed from the base of the papilla.

This union between the epithelial component and the dermal component marks the true birth of the hair follicle. It is at this stage that the construction of the hair really begins.

The papilla becomes the driving force of the follicle. Under its direction, the cells situated in the deeper part of the epithelial component, the matrix, multiply very rapidly.

Some form the external and internal epithelial sheaths of the follicle.

Others form the hair shaft. Unable to develop downwards, these cells will move upwards and the hair shaft will pierce the superficial layer of the epidermis, making the hair finally visible.

Throughout life, it is these same developmental processes which will continue to occur producing the growth cycle of hair.

LESSON 4: State and Federal Laws as they pertain to Cosmetologists, Cosmetology, Salons, Specialists, Specialty Salons, and Booth Renters: Chapter 477,F.S. And the Rules of the Board. (1 hour)

(a) The Laws and Rules of the Board that protect the Health, Safety and Welfare of the Consumer

(b) The Laws and Rules of the Board that determine where and when individuals may legally practice Cosmetology and Specialties

(c) The Functions of the Board of Cosmetology, how its member are appointed, and their duties

(d) The Laws and Rules of the Board which specify prohibited conduct and the penalties for failure to follow the laws and rules

(e) Salon Requirements and Inspections

(f) The dates, Fees, and Requirements for renewal of Cosmetology licenses, salon licenses and specialty registrations

CHAPTER 477

COSMETOLOGY

477.011 Short title.

477.012 Purpose.

477.013 Definitions.

477.0132 Hair braiding, hair wrapping, and body wrapping registration.

477.0135 Exemptions.

477.014 Qualifications for practice.

477.015 Board of Cosmetology.

477.016 Rulemaking.

477.017 Legal services.

477.018 Investigative services.

477.019 Cosmetologists; qualifications; licensure; supervised practice; license renewal; endorsement; continuing education.

477.0201 Specialty registration; qualifications; registration renewal; endorsement.

477.0212 Inactive status.

477.0213 Cosmetology graduates of Florida School for the Deaf and the Blind; licenses.

477.022 Examinations.

477.023 Schools of cosmetology; licensure.

477.025 Cosmetology salons; specialty salons; requisites; licensure; inspection; mobile cosmetology salons.

477.026 Fees; disposition.

477.0263 Cosmetology services to be performed in licensed salon; exception.

477.0265 Prohibited acts.

477.028 Disciplinary proceedings.

477.029 Penalty.

477.031 Civil proceedings.

477.011 Short title.--This act shall be known and may be cited as the "Florida Cosmetology Act."

History.--s. 1, ch. 78-253; s. 2, ch. 81-318; ss. 35, 36, ch. 85-297; s. 4, ch. 91-429.

477.012 Purpose.--The Legislature deems it necessary in the interest of public health to regulate the practice of cosmetology in this state. However, restrictions shall be imposed only to the extent necessary to

protect the public from significant and discernible danger to health and not in a manner which will unreasonably affect the competitive market. Further, consumer protection for both health and economic matters shall be afforded the public through legal remedies provided for in this act.

History.--s. 1, ch. 78-253; s. 2, ch. 81-318; ss. 35, 36, ch. 85-297; s. 4, ch. 91-429; s. 16, ch. 2000-332.

477.013 Definitions.--As used in this chapter:

(1) "Board" means the Board of Cosmetology.

(2) "Department" means the Department of Business and Professional Regulation.

(3) "Cosmetologist" means a person who is licensed to engage in the practice of cosmetology in this state

under the authority of this chapter.

(4) "Cosmetology" means the mechanical or chemical treatment of the head, face, and scalp for aesthetic

rather than medical purposes, including, but not limited to, hair shampooing, hair cutting, hair arranging,

hair coloring, permanent waving, and hair relaxing for compensation. This term also includes performing

hair removal, including wax treatments, manicures, pedicures, and skin care services.

(5) "Specialist" means any person holding a specialty registration in one or more of the specialties registered under this chapter.

(6) "Specialty" means the practice of one or more of the following:

(a) Manicuring, or the cutting, polishing, tinting, coloring, cleansing, adding, or extending of the nails, and massaging of the hands. This term includes any procedure or process for the affixing of artificial nails,

except those nails which may be applied solely by use of a simple adhesive.

(b) Pedicuring, or the shaping, polishing, tinting, or cleansing of the nails of the feet, and massaging or beautifying of the feet.

(c) Facials, or the massaging or treating of the face or scalp with oils, creams, lotions, or other preparations, and skin care services.

(7) "Shampooing" means the washing of the hair with soap and water or with a special preparation, or applying hair tonics.

(8) "Specialty salon" means any place of business wherein the practice of one or all of the specialties as defined in subsection (6) are engaged in or carried on.

(9) "Hair braiding" means the weaving or interweaving of natural human hair for compensation without

cutting, coloring, permanent waving, relaxing, removing, or chemical treatment and does not include the use of hair extensions or wefts.

(10) "Hair wrapping" means the wrapping of manufactured materials around a strand or strands of human hair, for compensation, without cutting, coloring, permanent waving, relaxing, removing, weaving, chemically treating, braiding, using hair extensions, or performing any other service defined as cosmetology.

(11) "Photography studio salon" means an establishment where the hair-arranging services and the application of cosmetic products are performed solely for the purpose of preparing the model or client for the photographic session without shampooing, cutting, coloring, permanent waving, relaxing, or removing of hair or performing any other service defined as cosmetology.

(12) "Body wrapping" means a treatment program that uses herbal wraps for the purposes of cleansing and beautifying the skin of the body, but does not include:

(a) The application of oils, lotions, or other fluids to the body, except fluids contained in presoaked materials used in the wraps; or

(b) Manipulation of the body's superficial tissue, other than that arising from compression emanating from the wrap materials.

(13) "Skin care services" means the treatment of the skin of the body, other than the head, face, and scalp,

by the use of a sponge, brush, cloth, or similar device to apply or remove a chemical preparation or other

substance, except that chemical peels may be removed by peeling an applied preparation from the skin by

hand. Skin care services must be performed by a licensed cosmetologist or facial specialist within a licensed cosmetology or specialty salon, and such services may not involve massage, as defined in s. 480.033(3), through manipulation of the superficial tissue.

History.--s. 1, ch. 78-253; ss. 13, 15, 25, 30, 34, 38, 62, ch. 80-406; s. 2, ch. 81-318; ss. 21, 35, 36, ch. 85-297; s. 1, ch. 87-69; s. 35, ch. 89-344; s. 4, ch. 91-429; s. 150, ch. 94-119; s. 166, ch. 94-218; s. 66, ch. 95-144; s. 7, ch. 98-323; s. 146, ch. 99-251; s. 68, ch. 2000-356.

477.0132 Hair braiding, hair wrapping, and body wrapping registration.--

(1)(a) Persons whose occupation or practice is confined solely to hair braiding must register with the department, pay the applicable registration fee, and take a two-day 16-hour course. The course shall be board approved and consist of 5 hours of HIV/AIDS and other communicable diseases, 5 hours of sanitation and sterilization, 4 hours of disorders and diseases of the scalp, and 2 hours of studies regarding

laws affecting hair braiding.

(b) Persons whose occupation or practice is confined solely to hair wrapping must register with the department, pay the applicable registration fee, and take a one-day 6-hour course. The course shall be board approved and consist of education in HIV/AIDS and other communicable diseases, sanitation and

sterilization, disorders and diseases of the scalp, and studies regarding laws affecting hair wrapping.

(c) Unless otherwise licensed or exempted from licensure under this chapter, any person whose

occupation or practice is body wrapping must register with the department, pay the applicable registration fee, and take a two-day 12-hour course. The course shall be board approved and consist of education in HIV/AIDS and other communicable diseases, sanitation and sterilization, disorders and diseases of the skin, and studies regarding laws affecting body wrapping.

(d) Only the board may review, evaluate, and approve a course required of an applicant for registration under this subsection in the occupation or practice of hair braiding, hair wrapping, or body wrapping. A provider of such a course is not required to hold a license under chapter 1005.

(2) Hair braiding, hair wrapping, and body wrapping are not required to be practiced in a cosmetology salon or specialty salon. When hair braiding, hair wrapping, or body wrapping is practiced outside a cosmetology salon or specialty salon, disposable implements must be used or all implements must be sanitized in a disinfectant approved for hospital use or approved by the federal Environmental Protection Agency.

(3) Pending issuance of registration, a person is eligible to practice hair braiding, hair wrapping, or body wrapping upon submission of a registration application that includes proof of successful completion of the education requirements and payment of the applicable fees required by this chapter.

History.--s. 151, ch. 94-119; s. 8, ch. 98-323; s. 147, ch. 99-251; s. 53, ch. 2000-356; s. 1021, ch. 2002-387.

477.0135 Exemptions.--

(1) This chapter does not apply to the following persons when practicing pursuant to their professional or occupational responsibilities and duties:

(a) Persons authorized under the laws of this state to practice medicine, surgery, osteopathic medicine, chiropractic medicine, massage, naturopathy, or podiatric medicine.

(b) Commissioned medical or surgical officers of the United States Armed Forces hospital services.

(c) Registered nurses under the laws of this state.

(d) Persons practicing barbering under the laws of this state.

(e) Persons employed in federal, state, or local institutions, hospitals, or military bases as cosmetologists

whose practices are limited to the inmates, patients, or authorized military personnel of such institutions, hospitals, or bases.

(f) Persons whose practice is limited to the application of cosmetic products to another person in connection with the sale, or attempted sale, of such products at retail without compensation from such other person other than the regular retail price of such merchandise.

(2) A license is not required of any person whose occupation or practice is confined solely to shampooing.

(3) A license or registration is not required of any person whose occupation or practice is confined solely

to cutting, trimming, polishing, or cleansing the fingernails of any person when said cutting, trimming, polishing, or cleansing is done in a barbershop licensed pursuant to chapter 476 which is carrying on a regular and customary business of barbering, and such individual has been practicing the activities set forth in this subsection prior to October 1, 1985.

(4) A photography studio salon is exempt from the licensure provisions of this chapter. However, the hairarranging

services of such salon must be performed under the supervision of a licensed cosmetologist employed by the salon. The salon must use disposable hair-arranging implements or use a wet or dry sanitizing system approved by the federal Environmental Protection Agency.

(5) A license is not required of any individual providing makeup, special effects, or cosmetology services

to an actor, stunt person, musician, extra, or other talent during a production recognized by the Office of

Film and Entertainment as a qualified production as defined in s. 288.1254(1). Such services are not required to be performed in a licensed salon. Individuals exempt under this subsection may not provide such services to the general public.

(6) A license is not required of any individual providing makeup or special effects services in a theme park or entertainment complex to an actor, stunt person, musician, extra, or other talent, or providing makeup or special effects services to the general public. The term "theme park or entertainment complex"

has the same meaning as in s. 509.013(9).

History.--ss. 68, 117, ch. 83-329; ss. 22, 35, 36, ch. 85-297; s. 2, ch. 87-69; s. 28, ch. 88-392; s. 4, ch. 91-429; s. 401, ch. 97-103; s. 54, ch. 97-264; ss. 217, 285, ch. 98-166; s. 9, ch. 98-323; s. 1, ch. 2004-284; s. 126, ch. 2008-4.

477.014 Qualifications for practice.--On and after January 1, 1979, no person other than a duly licensed

cosmetologist shall practice cosmetology or use the name or title of cosmetologist.

History.--s. 1, ch. 78-253; s. 2, ch. 81-318; ss. 35, 36, ch. 85-297; s. 36, ch. 89-344; s. 4, ch. 91-429.

477.015 Board of Cosmetology.--

(1) There is created within the department the Board of Cosmetology consisting of seven members, who

shall be appointed by the Governor, subject to confirmation by the Senate, and whose function it shall be

to carry out the provisions of this act.

(2) Five members of the board shall be licensed cosmetologists and shall have been engaged in the practice of cosmetology in this state for not less than 5 years. Two members of the board shall be laypersons. Each board member shall be a resident of this state and shall have been a resident of this state

for not less than 5 continuous years.

(3) The Governor may at any time fill vacancies on the board for the remainder of unexpired terms.

Each

member of the board shall hold over after the expiration of his or her term until a successor is duly appointed and qualified. No board member shall serve more than two consecutive terms, whether full or

partial.

(4) Before assuming his or her duties as a board member, each appointee shall take the constitutional oath

of office and shall file it with the Department of State, which shall then issue to such member a certificate

of his or her appointment.

(5) The board shall, in the month of January, elect from its number a chair and a vice chair.

(6) The board shall hold such meetings during the year as it may determine to be necessary, one of which

shall be the annual meeting. The chair of the board shall have the authority to call other meetings at his or

her discretion. A quorum of the board shall consist of not less than four members.

(7) Each member of the board shall receive \$50 for each day spent in the performance of official board business, with the total annual compensation per member not to exceed \$2,000. Additionally, board members shall receive per diem and mileage as provided in s. 112.061, from place of residence to place of

meeting and return.

(8) Each board member shall be held accountable to the Governor for the proper performance of all his or

her duties and obligations. The Governor shall investigate any complaints or unfavorable reports received

concerning the actions of the board, or its members, and shall take appropriate action thereon, which action may include removal of any board member. The Governor may remove from office any board member for neglect of duty, incompetence, or unprofessional or dishonorable conduct.

History.--s. 1, ch. 78-253; ss. 13, 15, 25, 30, 34, 39, 62, ch. 80-406; s. 2, ch. 81-318; ss. 23, 35, 36, ch. 85-297; s. 4, ch. 91-429; s. 167, ch. 94-218; s. 402, ch. 97-103.

477.016 Rulemaking.--

(1) The board may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this

chapter conferring duties upon it.

(2) The board may by rule adopt any restriction established by a regulation of the United States Food and

Drug Administration related to the use of a cosmetic product or any substance used in the practice of cosmetology if the board finds that the product or substance poses a risk to the health, safety, and welfare

of clients or persons providing cosmetology services.

History.--s. 1, ch. 78-253; ss. 13, 15, 25, 30, 34, 40, 62, ch. 80-406; s. 2, ch. 81-318; ss. 35, 36, ch. 85-297; s. 4, ch. 91-429; s. 149, ch. 98-200; s. 2, ch. 2004-284.

477.017 Legal services.--The department shall provide all legal services needed to carry out the provisions of this act.

History.--s. 1, ch. 78-253; s. 2, ch. 81-318; ss. 35, 36, ch. 85-297; s. 4, ch. 91-429.

477.018 Investigative services.--The department shall provide all investigative services required by the

board or the department in carrying out the provisions of this act.

History.--s. 1, ch. 78-253; ss. 13, 15, 25, 30, 34, 41, 62, ch. 80-406; s. 2, ch. 81-318; ss. 35, 36, ch. 85-297; s. 4, ch. 91-429.

477.019 Cosmetologists; qualifications; licensure; supervised practice; license renewal; endorsement; continuing education.--

(1) A person desiring to be licensed as a cosmetologist shall apply to the department for licensure.

(2) An applicant shall be eligible for licensure by examination to practice cosmetology if the applicant:

(a) Is at least 16 years of age or has received a high school diploma;

(b) Pays the required application fee, which is not refundable, and the required examination fee, which is refundable if the applicant is determined to not be eligible for licensure for any reason other than failure to

successfully complete the licensure examination; and

(c)1. Is authorized to practice cosmetology in another state or country, has been so authorized for at least 1

year, and does not qualify for licensure by endorsement as provided for in subsection (6); or

2. Has received a minimum of 1,200 hours of training as established by the board, which shall include, but

shall not be limited to, the equivalent of completion of services directly related to the practice of cosmetology at one of the following:

a. A school of cosmetology licensed pursuant to chapter 1005.

b. A cosmetology program within the public school system.

c. The Cosmetology Division of the Florida School for the Deaf and the Blind, provided the division meets the standards of this chapter.

d. A government-operated cosmetology program in this state.

The board shall establish by rule procedures whereby the school or program may certify that a person is qualified to take the required examination after the completion of a minimum of 1,000 actual school hours.

If the person then passes the examination, he or she shall have satisfied this requirement; but if the person

fails the examination, he or she shall not be qualified to take the examination again until the completion of

the full requirements provided by this section.

(3) An application for the licensure examination for any license under this section may be submitted for examination approval in the last 100 hours of training by a pregraduate of a licensed cosmetology school

or a program within the public school system, which school or program is certified by the Department of

Education with fees as required in paragraph (2)(b). Upon approval, the applicant may schedule the examination on a date when the training hours are completed. An applicant shall have 6 months from the

date of approval to take the examination. After the 6 months have passed, if the applicant failed to take the

examination, the applicant must reapply. The board shall establish by rule the procedures for the pregraduate application process.

(4) Upon an applicant receiving a passing grade, as established by board rule, on the examination and paying the initial licensing fee, the department shall issue a license to practice cosmetology.

(5) If an applicant passes all parts of the examination for licensure as a cosmetologist, he or she may practice in the time between passing the examination and receiving a physical copy of his or her license if

he or she practices under the supervision of a licensed cosmetologist in a licensed salon. An applicant who

fails any part of the examination may not practice as a cosmetologist and may immediately apply for

reexamination.

(6) Renewal of license registration shall be accomplished pursuant to rules adopted by the board.

(7) The board shall adopt rules specifying procedures for the licensure by endorsement of practitioners desiring to be licensed in this state who hold a current active license in another state and who have met qualifications substantially similar to, equivalent to, or greater than the qualifications required of applicants from this state.

(8)(a) The board shall prescribe by rule continuing education requirements intended to ensure protection

of the public through updated training of licensees and registered specialists, not to exceed 16 hours biennially, as a condition for renewal of a license or registration as a specialist under this chapter.

Continuing education courses shall include, but not be limited to, the following subjects as they relate to

the practice of cosmetology: human immunodeficiency virus and acquired immune deficiency syndrome;

Occupational Safety and Health Administration regulations; workers' compensation issues; state and federal laws and rules as they pertain to cosmetologists, cosmetology, salons, specialists, specialty salons,

and booth renters; chemical makeup as it pertains to hair, skin, and nails; and environmental issues.

Courses given at cosmetology conferences may be counted toward the number of continuing education hours required if approved by the board.

(b) Any person whose occupation or practice is confined solely to hair braiding, hair wrapping, or body wrapping is exempt from the continuing education requirements of this subsection.

(c) The board may, by rule, require any licensee in violation of a continuing education requirement to take

a refresher course or refresher course and examination in addition to any other penalty. The number of hours for the refresher course may not exceed 48 hours.

History.--s. 1, ch. 78-253; s. 1, ch. 80-132; ss. 13, 15, 25, 30, 34, 42, 62, ch. 80-406; s. 355, ch. 81-259; s. 2, ch. 81-318; ss. 69, 116, ch. 83-329; ss. 24, 35, 36, ch. 85-297; s. 3, ch. 87-69; s. 37, ch. 89-344; s. 1, ch. 90-4; s. 4, ch. 91-429; s. 403, ch. 97-103; s. 10, ch. 98-323; s. 163, ch. 99-251; s. 54, ch. 2000-356; s. 1022, ch. 2002-387; s. 29, ch. 2008-240.

477.0201 Specialty registration; qualifications; registration renewal; endorsement.--

(1) Any person is qualified for registration as a specialist in any one or more of the specialty practices within the practice of cosmetology under this chapter who:

(a) Is at least 16 years of age or has received a high school diploma.

(b) Has received a certificate of completion in a specialty pursuant to s. 477.013(6) from one of the following:

1. A school licensed pursuant to s. 477.023.

2. A school licensed pursuant to chapter 1005 or the equivalent licensing authority of another state.

3. A specialty program within the public school system.

4. A specialty division within the Cosmetology Division of the Florida School for the Deaf and the Blind,

provided the training programs comply with minimum curriculum requirements established by the board.

(2) A person desiring to be registered as a specialist shall apply to the department in writing upon forms prepared and furnished by the department.

(3) Upon paying the initial registration fee, the department shall register the applicant to practice one or more of the specialty practices within the practice of cosmetology.

(4) Renewal of registration shall be accomplished pursuant to rules adopted by the board.

(5) The board shall adopt rules specifying procedures for the registration of specialty practitioners desiring to be registered in this state who have been registered or licensed and are practicing in states which have registering or licensing standards substantially similar to, equivalent to, or more stringent than the standards of this state.

(6) Pending issuance of registration, a person is eligible to practice as a specialist upon submission of a registration application that includes proof of successful completion of the education requirements and payment of the applicable fees required by this chapter, provided such practice is under the supervision of a registered specialist in a licensed specialty or cosmetology salon.

History.--ss. 25, 36, ch. 85-297; s. 4, ch. 87-69; s. 4, ch. 91-429; s. 39, ch. 95-144; s. 11, ch. 98-323; s. 1023, ch. 2002-387.

477.0212 Inactive status.--

(1) A cosmetologist's license that has become inactive may be reactivated under s. 477.019 upon application to the department.

(2) The board shall promulgate rules relating to licenses which have become inactive and for the renewal

of inactive licenses. The board shall prescribe by rule a fee not to exceed \$50 for the reactivation of an inactive license and a fee not to exceed \$50 for the renewal of an inactive license.

History.--ss. 110, 117, ch. 83-329; ss. 27, 35, 36, ch. 85-297; s. 39, ch. 89-344; s. 4, ch. 91-429; s. 228, ch. 94-119.

477.0213 Cosmetology graduates of Florida School for the Deaf and the Blind; licenses.--The department shall license candidates upon graduation from the Cosmetology Division of the Florida School

for the Deaf and the Blind. The department shall, by rule, provide fees for licenses issued to candidates from the Cosmetology Division of the Florida School for the Deaf and the Blind and shall also provide, by

rule, for the type of licenses to be issued and for any required applications.

History.--s. 3, ch. 80-132; s. 2, ch. 81-318; ss. 35, 36, ch. 85-297; s. 4, ch. 91-429.

477.022 Examinations.--

(1) The board shall specify by rule the general areas of competency to be covered by examinations for the

licensing under this chapter of cosmetologists. The rules shall include the relative weight assigned in grading each area, the grading criteria to be used by the examiner, and the score necessary to achieve a passing grade. The board shall ensure that examinations adequately measure both an applicant's competency and her or his knowledge of related statutory requirements. Professional testing services may

be utilized to formulate the examinations. The board may, by rule, offer a written clinical examination or a

performance examination, or both, in addition to a written theory examination.

(2) The board shall ensure that examinations comply with state and federal equal employment opportunity guidelines.

(3) The examination shall be given at least once a year.

(4) The board shall adopt rules providing for reexamination of applicants who have failed the

examinations.

(5) All licensing examinations shall be conducted in such manner that the applicant shall be known by number only until her or his examination is completed and the proper grade determined. An accurate record of each examination shall be made; and that record shall be filed with the secretary of the department and shall be kept for reference and inspection for a period of not less than 2 years immediately following the examination.

History.--s. 1, ch. 78-253; ss. 13, 15, 25, 30, 34, 44, 62, ch. 80-406; s. 2, ch. 81-318; ss. 34, 46, ch. 82-179; s. 96, ch. 83-218; s. 71, ch. 83-329; ss. 35, 36, ch. 85-297; s. 40, ch. 89-344; s. 4, ch. 91-429; s. 404, ch. 97-103; s. 12, ch. 98-323.

477.023 Schools of cosmetology; licensure.--No private school of cosmetology shall be permitted to operate without a license issued by the Commission for Independent Education pursuant to chapter 1005.

However, nothing herein shall be construed to prevent certification by the Department of Education of cosmetology training programs within the public school system or to prevent government operation of any

other program of cosmetology in this state.

History.--s. 1, ch. 78-253; ss. 13, 15, 25, 30, 34, 45, 62, ch. 80-406; s. 2, ch. 81-318; ss. 35, 36, ch. 85-297; s. 41, ch. 89-344; s. 4, ch. 91-429; s. 38, ch. 98-421; s. 1024, ch. 2002-387.

477.025 Cosmetology salons; specialty salons; requisites; licensure; inspection; mobile cosmetology salons.--

(1) No cosmetology salon or specialty salon shall be permitted to operate without a license issued by the department except as provided in subsection (11).

(2) The board shall adopt rules governing the licensure and operation of salons and specialty salons and their facilities, personnel, safety and sanitary requirements, and the license application and granting process.

(3) Any person, firm, or corporation desiring to operate a cosmetology salon or specialty salon in the state shall submit to the department an application upon forms provided by the department and accompanied by any relevant information requested by the department and by an application fee.

(4) Upon receiving the application, the department may cause an investigation to be made of the proposed cosmetology salon or specialty salon.

(5) When an applicant fails to meet all the requirements provided herein, the department shall deny the application in writing and shall list the specific requirements not met. No applicant denied licensure because of failure to meet the requirements herein shall be precluded from reapplying for licensure.

(6) When the department determines that the proposed cosmetology salon or specialty salon may reasonably be expected to meet the requirements set forth herein, the department shall grant the license upon such conditions as it shall deem proper under the circumstances and upon payment of the original licensing fee.

(7) No license for operation of a cosmetology salon or specialty salon may be transferred from the name of the original licensee to another. It may be transferred from one location to another only upon approval

by the department, which approval shall not be unreasonably withheld.

(8) Renewal of license registration for cosmetology salons or specialty salons shall be accomplished pursuant to rules adopted by the board. The board is further authorized to adopt rules governing delinquent

renewal of licenses and may impose penalty fees for delinquent renewal.

(9) The board is authorized to adopt rules governing the periodic inspection of cosmetology salons and specialty salons licensed under this chapter.

(10)(a) The board shall adopt rules governing the licensure, operation, and inspection of mobile cosmetology salons, including their facilities, personnel, and safety and sanitary requirements.

(b) Each mobile salon must comply with all licensure and operating requirements specified in this chapter

or chapter 455 or rules of the board or department that apply to cosmetology salons at fixed locations, except to the extent that such requirements conflict with this subsection or rules adopted pursuant to this

subsection.

(c) A mobile cosmetology salon must maintain a permanent business address, located in the inspection area of the local department office, at which records of appointments, itineraries, license numbers of employees, and vehicle identification numbers of the licenseholder's mobile salon shall be kept and made

available for verification purposes by department personnel, and at which correspondence from the department can be received.

(d) To facilitate periodic inspections of mobile cosmetology salons, prior to the beginning of each month

each mobile salon licenseholder must file with the board a written monthly itinerary listing the locations

where and the dates and hours when the mobile salon will be operating.

(e) The board shall establish fees for mobile cosmetology salons, not to exceed the fees for cosmetology salons at fixed locations.

(f) The operation of mobile cosmetology salons must be in compliance with all local laws and ordinances

regulating business establishments, with all applicable requirements of the Americans with Disabilities Act

relating to accommodations for persons with disabilities, and with all applicable OSHA requirements.

(11) Facilities licensed under part II of chapter 400 or under part I of chapter 429 are exempt from this section, and a cosmetologist licensed pursuant to s. 477.019 may provide salon services exclusively for facility residents.

History.--s. 1, ch. 78-253; ss. 13, 15, 25, 30, 34, 46, 62, ch. 80-406; s. 2, ch. 81-318; ss. 29, 35, 36, ch. 85-297; s. 4, ch. 91-429; s. 13, ch. 98-323; s. 31, ch. 2002-223; s. 95, ch. 2006-197.

477.026 Fees; disposition.--

(1)The board shall set fees according to the following schedule:

(a)For cosmetologists, fees for original licensing, license renewal, and delinquent renewal shall not exceed \$50.

(b)For cosmetologists, fees for endorsement application, examination, and reexamination shall not

exceed \$50.

(c) For cosmetology and specialty salons, fees for license application, original licensing, license renewal, and delinquent renewal shall not exceed \$50.

(d) For specialists, fees for application and endorsement registration shall not exceed \$30.

(e) For specialists, fees for initial registration, registration renewal, and delinquent renewal shall not exceed \$50.

(f) For hair braiders, hair wrappers, and body wrappers, fees for registration shall not exceed \$25.

(2) All moneys collected by the department from fees authorized by this chapter shall be paid into the Professional Regulation Trust Fund, which fund is created in the department, and shall be applied in accordance with ss. 215.37 and 455.219. The Legislature may appropriate any excess moneys from this fund to the General Revenue Fund.

(3) The department, with the advice of the board, shall prepare and submit a proposed budget in accordance with law.

History.--s. 1, ch. 78-253; ss. 13, 15, 25, 30, 34, 47, 62, ch. 80-406; s. 2, ch. 81-318; ss. 24, 46, ch. 82-179; ss. 30, 35, 36, ch. 85-297; s. 5, ch. 87-69; s. 43, ch. 89-344; s. 4, ch. 91-429; s. 152, ch. 94-119; s. 14, ch. 98-323; s. 148, ch. 99-251; s. 21, ch. 2009-195.

477.0263 Cosmetology services to be performed in licensed salon; exception.--

(1) Cosmetology services shall be performed only by licensed cosmetologists in licensed salons, except as otherwise provided in this section.

(2) Pursuant to rules established by the board, cosmetology services may be performed by a licensed cosmetologist in a location other than a licensed salon, including, but not limited to, a nursing home, hospital, or residence, when a client for reasons of ill health is unable to go to a licensed salon. Arrangements for the performance of such cosmetology services in a location other than a licensed salon shall be made only through a licensed salon.

(3) Any person who holds a valid cosmetology license in any state or who is authorized to practice cosmetology in any country, territory, or jurisdiction of the United States may perform cosmetology services in a location other than a licensed salon when such services are performed in connection with the motion picture, fashion photography, theatrical, or television industry; a photography studio salon; a manufacturer trade show demonstration; or an educational seminar.

History.--ss. 75, 117, ch. 83-329; ss. 35, 36, ch. 85-297; s. 48, ch. 89-374; s. 4, ch. 91-429; s. 15, ch. 98-323.

477.0265 Prohibited acts.--

(1) It is unlawful for any person to:

(a) Engage in the practice of cosmetology or a specialty without an active license as a cosmetologist or registration as a specialist issued by the department pursuant to the provisions of this chapter.

(b) Own, operate, maintain, open, establish, conduct, or have charge of, either alone or with another person or persons, a cosmetology salon or specialty salon:

1. Which is not licensed under the provisions of this chapter; or

2. In which a person not licensed or registered as a cosmetologist or a specialist is permitted to perform

cosmetology services or any specialty.

(c) Engage in willful or repeated violations of this chapter or of any rule adopted by the board.

(d) Permit an employed person to engage in the practice of cosmetology or of a specialty unless such person holds a valid, active license as a cosmetologist or registration as a specialist.

(e) Obtain or attempt to obtain a license or registration for money, other than the required fee, or any other

thing of value or by fraudulent misrepresentations.

(f) Use or attempt to use a license to practice cosmetology or a registration to practice a specialty, which

license or registration is suspended or revoked.

(g) Advertise or imply that skin care services or body wrapping, as performed under this chapter, have any

relationship to the practice of massage therapy as defined in s. 480.033(3), except those practices or activities defined in s. 477.013.

(h) In the practice of cosmetology, use or possess a cosmetic product containing a liquid nail monomer containing any trace of methyl methacrylate (MMA).

(2) Any person who violates any provision of this section commits a misdemeanor of the second degree,

punishable as provided in s. 775.082 or s. 775.083.

History.--ss. 72, 117, ch. 83-329; ss. 31, 35, 36, ch. 85-297; s. 6, ch. 87-69; s. 110, ch. 91-224; s. 4, ch. 91-429; s. 149, ch. 99-251; s. 3, ch. 2004-284.

477.028 Disciplinary proceedings.--

(1) The board shall have the power to revoke or suspend the license of a cosmetologist licensed under this

chapter, or the registration of a specialist registered under this chapter, and to reprimand, censure, deny subsequent licensure or registration of, or otherwise discipline a cosmetologist or a specialist licensed or

registered under this chapter in any of the following cases:

(a) Upon proof that a license or registration has been obtained by fraud or misrepresentation.

(b) Upon proof that the holder of a license or registration is guilty of fraud or deceit or of gross negligence, incompetency, or misconduct in the practice or instruction of cosmetology or a specialty.

(c) Upon proof that the holder of a license or registration is guilty of aiding, assisting, procuring, or advising any unlicensed person to practice as a cosmetologist.

(2) The board shall have the power to revoke or suspend the license of a cosmetology salon or a specialty

salon licensed under this chapter, to deny subsequent licensure of such salon, or to reprimand, censure, or

otherwise discipline the owner of such salon in either of the following cases:

(a) Upon proof that a license has been obtained by fraud or misrepresentation.

(b) Upon proof that the holder of a license is guilty of fraud or deceit or of gross negligence, incompetency, or misconduct in the operation of the salon so licensed.

(3) Disciplinary proceedings shall be conducted pursuant to the provisions of chapter 120.

(4) The department shall not issue or renew a license or certificate of registration under this chapter to any

person against whom or salon against which the board has assessed a fine, interest, or costs associated with

investigation and prosecution until the person or salon has paid in full such fine, interest, or costs associated with investigation and prosecution or until the person or salon complies with or satisfies all terms and conditions of the final order.

History.--s. 1, ch. 78-253; s. 2, ch. 81-318; s. 73, ch. 83-329; ss. 32, 35, 36, ch. 85-297; s. 7, ch. 87-69; s. 44, ch. 89-344; s. 4, ch. 91-429; s. 16, ch. 98-323.

477.029 Penalty.--

(1) It is unlawful for any person to:

(a) Hold himself or herself out as a cosmetologist, specialist, hair wrapper, hair braider, or body wrapper unless duly licensed or registered, or otherwise authorized, as provided in this chapter.

(b) Operate any cosmetology salon unless it has been duly licensed as provided in this chapter.

(c) Permit an employed person to practice cosmetology or a specialty unless duly licensed or registered, or otherwise authorized, as provided in this chapter.

(d) Present as his or her own the license of another.

(e) Give false or forged evidence to the department in obtaining any license provided for in this chapter.

(f) Impersonate any other licenseholder of like or different name.

(g) Use or attempt to use a license that has been revoked.

(h) Violate any provision of s. 455.227(1), s. 477.0265, or s. 477.028.

(i) Violate or refuse to comply with any provision of this chapter or chapter 455 or a rule or final order of the board or the department.

(2) Any person who violates the provisions of this section shall be subject to one or more of the following penalties, as determined by the board:

(a) Revocation or suspension of any license or registration issued pursuant to this chapter.

(b) Issuance of a reprimand or censure.

(c) Imposition of an administrative fine not to exceed \$500 for each count or separate offense.

(d) Placement on probation for a period of time and subject to such reasonable conditions as the board may specify.

(e) Refusal to certify to the department an applicant for licensure.

History.--s. 1, ch. 78-253; s. 2, ch. 81-318; s. 74, ch. 83-329; ss. 33, 35, 36, ch. 85-297; s. 8, ch. 87-69; s. 45, ch. 89-344; s. 4, ch. 91-429; s. 10, ch. 94-119; s. 405, ch. 97-103; s. 126, ch. 98-166; s. 17, ch. 98-323; s. 150, ch. 99-251; s. 186, ch. 2000-160; s. 4, ch. 2004-284; s. 59, ch. 2009-195.

477.031 Civil proceedings.--As cumulative of any other remedy or criminal prosecution, the department

may file a proceeding in the name of the state seeking issuance of a restraining order, injunction, or writ of

mandamus against any person who is or has been violating any of the provisions of this chapter or the lawful rules or orders of the department.

History.--s. 1, ch. 78-253; s. 2, ch. 81-318; ss. 35, 36, ch. 85-297; s. 4, ch. 91-429.

Chapter 61G5, Florida Administrative Code

61G5-18.00015 Cosmetologist and Compensation Defined.

A cosmetologist is a person who is licensed to perform the mechanical or chemical treatment of the head, face, and scalp for aesthetic rather than medical purposes, including, but not limited to, hair shampooing, hair cutting, hair arranging, hair braiding, hair coloring, permanent waving, and hair relaxing, for compensation. A cosmetologist may also perform non-invasive hair removals, including wax treatments but not including electrolysis as that term is defined in Chapter 478, F.S., manicures, pedicures, and skin care services. For the purposes of this act “compensation” is defined as the payment of money or its equivalent, the receipt or delivery of property, or the performance of a service, or the receipt or delivery of anything of value in exchange for cosmetology services. For the purposes of this act “medical purposes” is defined as any form of bodily intrusion into the orifices, skin, muscles, or any other tissues of the body.

Specific Authority 477.016, 477.025(2) FS. Law Implemented 477.013, 477.025(2) FS. History—New 10-10-82,

Amended 6-28-84, Formerly 21F-18.001, Amended 7-4-90, Formerly 21F-18.00015, Amended 11-11-96, 3-8-00.

61G5-18.001 Who May Apply.

(1) Individuals desiring to be licensed as a cosmetologist shall meet all required qualifications as specified in Section 477.019, F.S.

(2) If an applicant for licensure by examination meets all required qualifications except the required minimum hours of training, he or she shall be entitled to take the licensure examination to practice cosmetology if the applicant has received a minimum of 1,000 hours of training established by the Board, and has been certified by the Director of the school or program in which he or she is currently enrolled to have achieved the minimum competency standards of performance as prescribed in Chapter 61G5-22, F.A.C., for the hours completed.

Specific Authority 477.016, 477.019(2) FS. Law Implemented 477.019(2) FS. History—New 11-3-80, Amended

12-18-83, Formerly 21F-18.01, Amended 10-18-87, 1-10-90, 12-17-90, Formerly 21F-18.001, Amended 2-1-98.

61G5-18.002 Manner of Application.

Every person desiring to be examined for licensure as a cosmetologist shall apply to the department in writing upon

forms prepared and furnished by the Department and pay an examination fee as required by Chapter 61G5-24, F.A.C.

(1) The applicant must present an application and evidence of completion of cosmetologist training defined in Rule

61G5-18.001, F.A.C., above. Applications will be scheduled on an as available basis.

(2) The Department shall notify the applicant fourteen (14) days prior to the examination if the applicant is eligible to take the examination.

Specific Authority 120.53, 477.016 FS. Law Implemented 477.019 FS. History—New 11-3-80, Amended 1-17-83,

Formerly 21F-18.02, Amended 6-22-87, Formerly 21F-18.002, Amended 7-30-02.

61G5-18.003 Cosmetology Examination.

(1) The Cosmetology examination shall consist of two parts, a written theory examination and a written clinical

examination, both parts must be successfully completed prior to licensure.

(2)(a) The written theory examination shall be administered by the Department. The following subjects will be tested

on the examination and will be weighted approximately as designated:

Category Weight

1. General Safety and Sanitation Procedures 34%

2. Client Services 24%

3. Facial, Make-up, and Hair Removal 16%

4. Manicuring and Pedicuring 16%

5. Professional/Legal and Ethical Laws and Rules 10%

(b) Passing Grade. Candidates' scores will be converted to a scale of 0 to 100; the minimum passing score as

determined by the Board shall be set at 75 on that scale. All forms of the examination are statistically equated so that

the relative passing scores remain equivalent.

(3) The second part of the examination shall be a written clinical examination administered by the Department. The

following subjects will be tested on the examination and will be weighted approximately as follows:

Category Weight

(a) Hair Coloring and Lightening 39%

(b) Permanent Waving and Chemical Relaxing 34%

(c) Scalp and Hair Care 5%

(d) Hair Cutting/Shaping 10%

(e) Hair Styling 12%

(4) Passing Grade. Candidates' scores will be converted to a scale of 0 to 100; the minimum passing score as

determined by the Board shall be set at 75 on that scale. All forms of the examination are statistically equated so that

the relative passing scores remain equivalent.

(5) In rounding percentages, any percentage which is point five (.5) or above shall be rounded up to the next number.

Percentages less than point five (.5) shall be rounded down to the next whole number.

(6) An accurate record of each examination shall be made and the record, together with all examination papers, shall

be filed with the Secretary of the Department and shall be kept for reference and inspection for a period of not less

than two (2) years immediately following the examination.

(7) An applicant shall be permitted to use a strict translation dictionary in taking the examination. Such a dictionary

shall give only the translation of words from one language to another without giving any definition or explanation of

any word.

Specific Authority 120.53, 455.217(1), 477.016 FS. Law Implemented 455.217(3), 477.022 FS.

History—New 1-1-81,

Amended 4-7-81, 6-17-81, 6-3-82, 10-10-82, 1-17-83, 8-10-83, 6-28-84, 8-8-84, 4-18-85, 5-19-85,

Formerly

21F-18.03, Amended 3-10-86, 8-10-86, 10-18-87, 8-29-88, Formerly 21F-18.003, Amended 4-16-96, 8-20-96.

61G5-18.004 Re-examination.

(1) Any applicant who fails the examination shall be entitled to re-examination pursuant to the terms and conditions

set forth in this rule. Those applicants not achieving a passing grade on each part will have failed that part of the

examination and shall be required to retake and pass only that part failed in order to be licensed as a cosmetologist,

provided however that the applicant must pass both parts of the examination within a two-year period.

If any applicant

fails to achieve a passing grade on all parts within the 2 years as provided in this rule, the applicant shall be required

to retake and successfully complete the full examination. In rounding percentages, any percentage which is point five

(.5) or above shall be rounded up to the next whole number. Percentages less than point five (.5) shall be rounded

down to the next whole number.

(2) Any person desiring to be reexamined for licensure as a cosmetologist shall apply to the Department in writing

upon forms prepared and furnished by the department and shall pay a reexamination fee as required by Rule

61G5-24.006, F.A.C.

(3) Those applicants who qualified to take the examination after completion of only 1,000 hours of training pursuant

to Section 477.019(1)(b), F.S., and failed, shall be entitled to reexamination only upon completion of the full

requirements provided for in Section 477.019, F.S.

(4) An applicant who has twice failed the examination or any part thereof, shall return to an approved school of

cosmetology for a minimum of 40 hours of remedial instruction prior to taking any part of the examination for the

third time. An applicant who fails any portion for the third time shall return to an approved school of cosmetology for

80 hours of remedial instruction.

Specific Authority 120.53, 455.217(1), 477.016 FS. Law Implemented 455.217(2), 477.022 FS.

History—New 11-3-80,

Amended 8-10-83, 6-28-84, Formerly 21F-18.04, Amended 6-18-86, Formerly 21F-18.004, Amended 8-20-96.

61G5-18.005 Examination Review Procedure.

(1) An applicant is entitled to review his examination questions, answers, papers, grades and grading key used in the

state examination for licensure under such terms and conditions as may be prescribed by the Department of Business

and Professional Regulation; however, no applicant may copy any materials provided for his review. Such review

shall be conducted in accord with Rule 61-11.011, F.A.C., during regular business hours in the presence of a

representative of the Department, in the Office of Examination Services of the Department.

(2) If, following the review of his examination, an applicant believes that an error was made in the grading of his

examination, or in the evaluation of his answers, he may request that the Department review his examination.

Requests for review must be in writing, state with specificity the reasons why review is requested, and must be

received by the Department within thirty (30) days after the applicant receives notice that he failed the examination.

(3) Upon the receipt of a request for review, and appropriate fee as described in Rule 61G5-24.018, F.A.C., the

Department shall review the applicant's examination. If the Department finds that an error was made, the Department

may adjust the grade received by the applicant to reflect the correction. The applicant shall be notified of the decision.

Specific Authority 477.016, 455.217(2) FS. Law Implemented 455.217(2) FS. History—New 11-3-80, Formerly

12F-18.05, Amended 8-20-90, Formerly 21F-18.005.

61G5-18.0055 Supervised Cosmetology Practice Exception.

Following the completion of the first licensing examination by a graduate of licensed cosmetology school or cosmetology program offered in a public school system, which school or program is certified by the Department of Education, an applicant for licensure as a cosmetologist by examination is eligible to practice temporarily in a current, actively licensed cosmetology salon under the following conditions:

(1) In the event an applicant obtains passing scores on the first attempt of both the written and

clinical examinations, the applicant shall be eligible, prior to having their application acted on by the Board, to practice cosmetology in a licensed salon, provided that they post their examination results for both examinations at their work station with a recent photograph affixed thereto.

(2) An applicant who fails any part of the examination may not practice as a cosmetologist and may immediately apply for reexamination.

Rulemaking Authority 477.016, 477.019(4) FS. Law Implemented 477.019(4), (5) FS. History—New 11-25-98, Amended 2-25-07, 5-19-09.

61G5-18.007 Endorsement of Cosmetologists.

The Department of Business and Professional Regulation shall issue a license to an applicant without examination

who:

(1) Makes application and pays to the Department the fee specified in Rule 61G5-24.002, F.A.C.;

(2) Demonstrates that the applicant is currently licensed to practice cosmetology under the law of another state;

(3) Demonstrates that the applicant has completed at least 1200 cosmetology school or program hours substantially

similar to, equivalent to, or greater than the qualifications required of applicants from this state;

(4) Demonstrates that the applicant has passed a written licensure examination to obtain a license substantially similar

to, equivalent to, or greater than the qualifications required of applicants from this state; and

(5) Demonstrates that the applicant has completed a board approved HIV/AIDS course.

Specific Authority 477.016, 477.019(6) FS. Law Implemented 477.019(6) FS. History—New 11-3-80, Formerly

21F-18.07, Amended 6-22-87, 10-18-87, 12-17-90, Formerly 21F-18.007, Amended 7-1-02.

61G5-18.008 Cosmetologist License Renewal.

(1) A cosmetologist shall renew his or her license on or before October 31 each biennial year, according to the fee

schedule as outlined in Rule 61G5-24.008, F.A.C.

(2) Spouses of members of the Armed Forces of the United States are exempted from all licensure renewal provisions,

but only in cases of absence from the state because of their spouses' duties with the Armed Forces.

Specific Authority 455.02(2), 477.016, 477.019(4) FS. Law Implemented 455.02(2), 477.019(4) FS. History—New

11-3-80, Amended 6-28-84, 10-6-85, Formerly 21F-18.08, 21F-18.008, Amended 8-8-95.

61G5-18.011 Initial Licensure or Registration Requirement for Instruction on Human Immunodeficiency Virus

and Acquired Immune Deficiency Syndrome; Course Content and Approval Requirements.

(1) Each applicant for initial licensure or registration under Chapter 477, F.S., shall complete a board-approved

educational course on Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS),

and shall submit proof thereof in the form of a certificate of completion from the provider of such course with the

application. A copy of the certificate will satisfy this requirement. Completion of such course shall be a

condition of

licensure or registration. Except as provided in subsection (2) below, no person shall be granted an initial license or registration unless he or she complies with this rule.

(2) If an applicant for initial licensure or registration under Chapter 477, F.S., has not completed a board-approved

educational course on HIV and AIDS at the time of application, but has completed all other requirements for licensure

or registration, he or she may request an additional 6 month period in which to complete this requirement. Such

request shall be submitted at the time of filing the application for licensure or registration; and, will be made by filing

a written affidavit showing good cause to grant the request. Upon the filing of such affidavit, the applicant shall be

granted one, 6 month period in which to complete a board-approved educational course on HIV and AIDS. The

applicant shall be required to submit proof of the completion of this course in the form of a certificate of completion

from the provider of such course to the department within the 6 month period. A copy of the certificate will satisfy this

requirement. Failure to submit such proof during the 6 month period shall cause any previously issued license or

registration to become null and void without further action by the Board.

(3) All educational courses on HIV and AIDS which are taught to fulfill the requirements for initial licensure or

registration under Chapter 477, F.S., shall be approved by the Board. To be considered for the Board's approval,

courses on HIV and AIDS shall consist of 4 hours combined education of:

(a) Education on the modes of transmission, infection control procedures, clinical management, and prevention of

HIV and AIDS;

(b) Discussion of attitudes towards HIV and AIDS as well as appropriate behavior in dealing with persons who may

have the virus or syndrome.

(4) All proposed HIV and AIDS educational courses shall be submitted for presentation to the Board at least 30 days

prior to the next scheduled board meeting at which the course is to be considered for approval. No course may be

taught for credit until it has received the Board's approval.

(5) The Board approves the following courses for purposes of fulfilling the requirements for initial licensure or

registration under Chapter 477, F.S.:

(a) Courses approved by any other board in accordance with Section 381.0034, 381.0035, 455.2226, or 455.2228, F.

S.;

(b) Basic AIDS educational courses presented by the Florida Department of Health or other state health departments,

provided they meet the requirements set forth in subsection (3).

(6) Home study or video courses shall be approved by the Board, provided they meet the requirements set forth in subsection (3). Home study courses must require a 75% passing score on a post course test to be graded by the course provider.

(7) At any time, the Board shall deny or rescind its approval of a course offered for initial licensure if it finds that:

such approval was the result of fraud; the course which is being provided fails to cover the information required by

statute or subsection (3) or fails to meet other requirements specified in this rule; or the course significantly varies

from the course proposal that was approved by the Board. Before rescinding approval of a course, the Board shall give

the course provider notice and an opportunity to be heard. If the Board denies or rescinds its approval of a course

because of the course provider's fraud in obtaining such approval, then the course provider shall thereafter be barred

from presenting any other course to licensees for credit unless the course provider demonstrates to the Board that he

or she has been sufficiently rehabilitated to be trusted to provide such courses to licensees in the future.

Specific Authority 455.2228(5), 477.016 FS. Law Implemented 455.2228 FS. History—New 9-2-90, Amended 4-9-91,

10-27-91, 6-14-93, Formerly 21F-18.011, Amended 2-1-95, 12-21-97, 1-31-99, 3-8-00, 5-10-01, 8-1-05.

61G5-20.001 Salon Defined .

Salon means any establishment or place of business wherein cosmetology as defined in Section 477.013(4), F.S., or

any specialty as defined in Section 477.013(6), F.S., is practiced for compensation, however this does not prevent the

practice of cosmetology in a licensed barbershop, or the practice of barbering in a licensed cosmetology salon,

provided the salon employs a licensed cosmetologist. Except as provided in Rule 61G5-20.010, F.A.C., a salon must

be at a fixed location.

Specific Authority 477.016 FS. Law Implemented 477.025 FS. History—New 11-2-80, Amended 10-10-82, 10-6-85,

Formerly 21F-20.01, Amended 10-18-87, Formerly 21F-20.001, Amended 2-10-94, 2-25-07.

61G5-20.0015 Performance of Cosmetology or Specialty Services Outside a Licensed Salon.

(1) Cosmetology or specialty services may be performed by a licensed cosmetologist or specialist in a location other

than a licensed salon, including a hospital, nursing home, residence, or similar facility, when a client for reasons of ill

health is unable to go to a licensed salon. The following procedure shall be followed:

(a) Arrangements shall be made through a licensed salon.

(b) Information as to the name of the client and the address at which the services are to be performed shall be recorded in the appointment book.

(c) The appointment book shall remain at the salon and be made available upon request to any investigator or inspector of the Department.

(2) When cosmetology or specialty services are performed in a location other than a licensed salon, such services may lawfully be performed only upon clients, residents, or patients, who for reasons of ill health are unable to visit a licensed salon. Such services are not to be performed upon employees or persons who do not reside in the facility, or any other non-qualified persons.

(3) Cosmetology services may only be performed in a photography studio salon subject to the following requirements:

(a) Only hair-arranging services and the application of cosmetic products may be performed in a photography studio

salon; and, may only be performed for the purpose of preparing a model or client of the photography studio for a photographic session. Shampooing the hair, hair cutting, hair coloring, permanent waving of the hair, hair relaxing,

removing of hair, manicuring, pedicuring, and the performance of any other service defined as cosmetology may not be performed in a photography studio salon.

(b) All hair-arranging services and applications of cosmetic products to be performed in the photography studio salon

shall be performed by a licensed Florida cosmetologist or under the supervision of a licensed cosmetologist employed

by the salon. "Under the supervision of a licensed cosmetologist" shall mean that an individual who then holds a

current, active Florida license as a cosmetologist shall be physically present at the photography studio salon at all

times when hair-arranging services or applications of cosmetic products are being performed.

(c) When performing hair-arranging services, the photography studio salon shall use either disposable hair-arranging

implements or shall use a wet or dry sanitizing system approved by the federal Environmental Protection Agency.

Specific Authority 477.016, 477.025(2), 477.0263(2),(3), 477.0135(4) FS. Law Implemented 477.025(2), 477.0263(2),

(3), 477.0135(4) FS. History—New 12-29-83, Amended 10-6-85, Formerly 21F-20.015, 21F-20.0015, Amended

11-25-98.

61G5-20.00175 Fashion Photography.

For purposes of Section 477.0263(3), F.S., fashion photography is hereby defined to mean the photographing of one or

more human subjects or professional models for commercial purposes where the subject or model

receives

remuneration, compensation or wages for being photographed. Fashion photography shall not include instances in

which the subject pays a photographer a fee to be photographed or instances in which the photographs are made for

the personal use and enjoyment of the subject rather than for commercial purposes.

Specific Authority 477.016 FS. Law Implemented 477.0263(3) FS. History—New 1-9-95.

61G5-20.002 Salon Requirements .

(1) Prior to opening a salon, the owner shall:

(a) Submit an application on forms prescribed by the Department of Business and Professional Regulation; and

(b) Pay the required registration fee as outlined in the fee schedule in Rule 61G5-24.005, F.A.C.; and

(c) Meet the safety and sanitary requirements as listed below and these requirements shall continue in full force and

effect for the life of the salon:

1. Ventilation and Cleanliness: Each salon shall be kept well ventilated. The walls, ceilings, furniture and equipment

shall be kept clean and free from dust. Hair must not be allowed to accumulate on the floor of the salon. Hair must be

deposited in a closed container. Each salon which provides services for the extending or sculpturing of nails shall

provide such services in a separate area which is adequately ventilated for the safe dispersion of all fumes resulting

from the services.

2. Toilet and Lavatory Facilities: Each salon shall provide – on the premises or in the same building as, and within 300

feet of, the salon – adequate toilet and lavatory facilities. To be adequate, such facilities shall have at least one toilet

and one sink with running water. Such facilities shall be equipped with toilet tissue, soap dispenser with soap or other

hand cleaning material, sanitary towels or other hand-drying device such as a wall-mounted electric blow dryer, and

waste receptacle. Such facilities and all of the foregoing fixtures and components shall be kept clean, in good repair,

well-lighted, and adequately ventilated to remove objectionable odors.

3. A salon, or specialty salon may be located at a place of residence. Salon facilities must be separated from the living

quarters by a permanent wall construction. A separate entrance shall be provided to allow entry to the salon other than

from the living quarters. Toilet and lavatory facilities shall comply with subparagraph (c)2. above and shall have an

entrance from the salon other than the living quarters.

4. Animals: No animals or pets shall be allowed in a salon, with the exception of fish kept in closed aquariums, or

trained animals to assist the hearing impaired, visually impaired, or the physically disabled.

5. Shampoo Bowls: Each salon shall have shampoo bowls equipped with hot and cold running water.

The shampoo

bowls shall be located in the area where cosmetology services are being performed. A specialty salon that exclusively provides specialty services, as defined in Section 477.013(6), F.S., need not have a shampoo bowl, but must have a sink or lavatory equipped with hot and cold running water on the premises of the salon.

(d) Comply with all local building and fire codes. These requirements shall continue in full force and effect for the life of the salon.

(2) Each salon shall comply with the following:

(a) Linens: Each salon shall keep clean linens in a closed, dustproof cabinet. All soiled linens must be kept in a closed

receptacle. Soiled linens may be kept in open containers if entirely separated from the area in which cosmetology

services are rendered to the public. A sanitary towel or neck strip shall be placed around the patron's neck to avoid

direct contact of the shampoo cape with a patron's skin.

(b) Containers: Salons must use containers for waving lotions and other preparations of such type as will prevent

contamination of the unused portion. All creams shall be removed from containers by spatulas.

(c) Sterilization and Disinfection: The use of a brush, comb or other article on more than one patron without being

disinfected is prohibited. Each salon is required to have sufficient combs, brushes, and implements to allow for

adequate disinfecting practices. Combs or other instruments shall not be carried in pockets.

(d) Sanitizers: All salons shall be equipped with and utilize wet sanitizers with hospital level disinfectant or EPA

approved disinfectant, sufficient to allow for disinfecting practices.

1. A wet sanitizer is any receptacle containing a disinfectant solution and large enough to allow for a complete

immersion of the articles. A cover shall be provided.

2. Disinfecting methods which are effective and approved for salons: First, clean articles with soap and water,

completely immerse in a chemical solution that is hospital level or EPA approved disinfectant as follows:

a. Combs and brushes, remove hair first and immerse in hospital level or EPA approved disinfectant;

b. Metallic instrument, immerse in hospital level for EPA approved disinfectant;

c. Instruments with cutting edge, wipe with a hospital level or EPA approved disinfectant; or

d. Implements may be immersed in a hospital level or EPA approved disinfectant solution.

3. For purposes of this rule, a "hospital level disinfectant or EPA approved disinfectant" shall mean the following:

a. For all combs, brushes, metallic instruments, instruments with a cutting edge, and implements that have not come

into contact with blood or body fluids, a disinfectant that indicates on its label that it has been registered with the EPA

as a hospital grade bacterial, virucidal and fungicidal disinfectant;

b. For all combs, brushes, metallic instruments with a cutting edge, and implements that have come into

contact with

blood or body fluids, a disinfectant that indicates on its label that it has been registered with the EPA as a

tuberculocidal disinfectant, in accordance with 29 C.F.R. 1910.1030.

4. All disinfectants shall be mixed and used according to the manufacturer's directions.

(e) After cleaning and disinfecting, articles shall be stored in a clean, closed cabinet or container until used.

Undisinfected articles such as pens, pencils, money, paper, mail, etc., shall not be kept in the same container or

cabinet. For the purpose of recharging, rechargeable clippers may be stored in an area other than in a closed cabinet or

container, provided such area is clean and provided the cutting edges of such clippers have been disinfected.

(f) Ultra Violet Irradiation may be used to store articles and instruments after they have been cleansed and disinfected.

(g) Pedicure Equipment Sterilization and Disinfection:

The following cleaning and disinfection procedures must be used for any pedicure equipment that holds water,

including sinks, bowls, basins, pipe-less spas, and whirlpool spas:

1. After each client, all pedicure units must be cleaned with a low-foaming soap or detergent with water to remove all

visible debris, then disinfected with an EPA registered hospital grade bactericidal, fungicidal, virucidal, and

pseudomonacidal disinfectant used according to manufacturers instructions for at least ten (10) minutes. If the pipefree

foot spa has a foot plate, it should be removed and the area beneath it cleaned, rinsed, and wiped dry.

2. At the end of each day of use, the following procedures shall be used:

a. All filter screens in whirlpool pedicure spas or basins for all types of foot spas must be sanitized. All visible debris

in the screen and the inlet must be removed and cleaned with a low-foaming soap or detergent and water. For pipefree

systems, the jet components or foot plate must be removed and cleaned and any debris removed. The screen, jet,

or foot plate must be completely immersed in an EPA registered, hospital grade bactericidal, fungicidal, virucidal, and

pseudomonacidal disinfectant that is used according to manufacturer's instructions. The screen, jet, or foot plate must

be replaced after disinfection is completed and the system is flushed with warm water and low-foaming soap for 5

minutes, rinsed, and drained.

b. After the above procedures are completed, the basin should be filled with clean water and the correct amount of

EPA registered disinfectant. The solution must be circulated through foot spa system for 10 minutes and the unit then

turned off. The solution should remain in the basin for at least 6 to 10 hours. Before using the equipment again, the

basin system must be drained and flushed with clean water.

3. Once each week, subsequent to completing the required end-of-day cleaning procedures, the basin must be filled with a solution of water containing one teaspoon of 5.25% bleach for each gallon of water. The solution must be circulated through the spa system for 5 to 10 minutes and then the solution must sit in the basin for at least 6 hours.

Before use, the system must be drained and flushed.

4. A record or log book containing the dates and times of all pedicure cleaning and disinfection procedures must be documented and kept in the pedicure area by the salon and made available for review upon request by a consumer or a Department inspector.

(3) No cosmetology or specialty salon shall be operated in the same licensed space allocation with any other business which adversely affects the sanitation of the salon, or in the same licensed space allocation with a school teaching cosmetology or a specialty licensed under Chapter 477, F.S., or in any other location, space, or environment which adversely affects the sanitation of the salon. In order to control the required space and maintain proper sanitation, where a salon adjoins such other business or school, or such other location, space or environment, there must be permanent walls separating the salon from the other business, school, location, space, or environment and there must be separate and distinctly marked entrances for each.

(4) Evidence that the full salon contains a minimum of 200 square feet of floor space. No more than two (2)

cosmetologists or specialists may be employed in a salon which has only the minimum floor space.

(5) A specialty salon offering only one of the regulated specialties shall evidence a minimum of 100 square feet used in the performance of the specialty service and shall meet all the sanitation requirements stated in this section. No

more than one specialist or cosmetologist may be employed in a specialty salon with only the minimum floor space.

An additional 50 square feet will be required for each additional specialist or cosmetologist employed.

(6) For purposes of this rule, "permanent wall" means a vertical continuous structure of wood, plaster, masonry, or other similar building material, which is physically connected to a salon's floor and ceiling, and which serves to delineate and protect the salon.

Specific Authority 477.016, 477.025(2) FS. Law Implemented 477.025 FS. History—New 4-22-81, Amended 9-11-81,

1-17-83, 8-10-83, 6-28-84, 10-6-85, Formerly 21F-20.02, Amended 6-18-86, 10-18-87, 8-20-90, 5-19-91, 1-30-92,

5-11-92, 4-15-93, 5-31-93, Formerly 21F-20.002, Amended 1-9-95, 4-5-95, 8-8-95, 2-28-96, 6-16-97, 8-27-98,

4-13-99, 8-1-05, 9-6-06, 2-25-07, 3-10-08.

61G5-20.003 Inspections.

The Department of Business and Professional Regulation shall cause an inspection of all proposed salons to determine if all the requirements have been met. Each licensed salon shall be inspected at least biennially by the Department. No person shall, for any reason intentionally, or directly inhibit an authorized representative of the Department from performing said inspections.

Specific Authority 477.016 FS. Law Implemented 477.025(4),(9) FS. History—New 4-22-81, Amended 9-11-81, 5-3-82, 10-6-85, Formerly 21F-20.03, Amended 10-18-87, Formerly 21F-20.003, Amended 9-27-07.

61G5-20.004 Display of Documents .

(1) All holders of a cosmetology or specialty salon license shall display within their salons in a conspicuous place

which is clearly visible to the general public upon entering the salon the following documents:

(a) The current salon license,

(b) A legible copy of the most recent inspection sheet for the salon.

(2) All holders of a cosmetology or specialty salon license shall require and ensure that all individuals engaged in the

practice of cosmetology, any specialty, hair braiding, hair wrapping, or body wrapping display at the individual's work

station their current license or registration at all times when the individual is performing cosmetology, specialty, hair

braiding, hair wrapping, or body wrapping services. The license or registration on display shall be the original

certificate or a duplicate issued by the Department and shall have attached a 2" by 2" photograph taken within the

previous two years of the individual whose name appears on the certificate. The certificate with photograph attached

shall be permanently laminated as of July 1, 2007.

(3) By July 1, 2008, all holders of a cosmetology or specialty salon license shall display at each footbath a copy of the

Consumer Protection Notice regarding footbaths, sanitation, and safety. Copies of this notice (revised 10/15/07, and

incorporated herein by reference) may be obtained from the Department of Business and Professional Regulation at

1940 North Monroe St., Tallahassee, FL 32399-0783, and the Call Center by calling (850)487-1395.

Specific Authority 477.016, 477.025(2) FS. Law Implemented 477.025 FS. History—New 11-2-80, Amended 10-10-82,

6-28-84, 10-6-85, Formerly 21F-20.04, 21F-20.004, Amended 3-22-00, 12-6-06, 3-10-08.

61G5-20.005 Salon License Renewal.

All salon licenses shall be renewed on or before November 30 of each biennial (even-numbered) year, by meeting all

the current requirements for salon licensure as expressed in Rule Chapter 61G5-20, F.A.C., and by paying the renewal

fee specified in Rule 61G5-24.009, F.A.C. A salon license is delinquent if not renewed by the November 30 renewal date. To renew a delinquent license, a licensee shall pay delinquent fee as outlined in Rule 61G5-24.009, F.A.C. (in addition to the biennial renewal fee). A delinquent salon license shall expire at the end of the biennium in which it becomes delinquent. After a salon license has expired at the end of the biennium, a new salon license application, the delinquent fee as outlined in Rule 61G5-24.009, F.A.C., and all fees as outlined in Rule 61G5-24.005, F.A.C., must be filed with the Board. Until such new license is issued for and received by the salon, all cosmetology and specialty services shall cease.

Specific Authority 477.016, 477.025, 477.026 FS. Law Implemented 477.025(8), 477.026(1)(c) FS. History—New 11-2-80, Amended 5-3-82, 10-6-85, Formerly 21F-20.05, Amended 1-28-91, Formerly 21F-20.005, Amended 2-28-96, 8-20-96, 10-1-97.

61G5-20.006 Transfer of Ownership or Location of a Salon.

No salon license may be transferred from the name of one licensee to another. A salon license may be transferred from one location to another only by filing a new application and fee and obtaining departmental approval, pursuant to the requirements of Rule 61G5-20.002, F.A.C., prior to transferring the license.

Specific Authority 477.016 FS. Law Implemented 477.025(7) FS. History—New 5-12-81, Amended 10-6-85, Formerly 21F-20.06, 21F-20.006, Amended 10-30-97.

61G5-20.007 Communicable Disease.

(1) No person engaged in the practice of cosmetology or a specialty in a salon shall proceed with any service to a person having a visible disease, pediculosis, or open sores suggesting a communicable disease, until such person furnishes a statement signed by a physician licensed to practice in the State of Florida stating that the disease or condition is not in an infectious, contagious or communicable stage.

(2) No cosmetologist or person registered to practice any specialty in Florida, who has a visible disease, pediculosis, or open sores suggesting a communicable disease, shall engage in the practice of cosmetology or any specialty, until such cosmetologist or registrant obtains a statement signed by a physician licensed to practice in the State of Florida stating that the disease or condition is not in an infectious, contagious, or communicable stage.

Specific Authority 477.016 FS. Law Implemented 477.025(2) FS. History—New 5-12-81, Amended 10-6-85, Formerly 21F-20.07, Amended 5-11-92, Formerly 21F-20.007.

61G5-20.008 Employment of Applicants for Licensure as a Cosmetologist Prior to Licensure; Employment of Applicants for Registration as a Specialist Prior to Registration.

(1) Holders of a cosmetology salon license who wish to permit an applicant for licensure as a cosmetologist by examination to perform cosmetology services in their salon pursuant to Rule 61G5-18.0055, F.A.C., shall:

(a) Prior to permitting an applicant to perform cosmetology services in their salon, obtain from the applicant a copy of the completed application for licensure by examination submitted to the Department by the applicant, and a copy of the notification by the Department to the applicant that he or she has been scheduled to take the licensure examination.

The cosmetology salon license holder shall not permit an applicant to practice cosmetology or perform cosmetology services in the salon until after the date of the licensure examination as indicated on the notification from the Department.

(b) Upon learning or in any way becoming aware that an applicant who is performing cosmetology services in their salon pursuant to Rule 61G5-18.0055, F.A.C., has either failed to take the first licensure examination as scheduled by the Department, or has failed to achieve a passing grade on the first licensure examination taken by the applicant, immediately cease to permit the applicant to further perform cosmetology services until the applicant provides to the cosmetology salon license holder a copy of the completed application for reexamination submitted to the Department by the applicant for the next available licensure examination immediately following the licensure examination which the applicant failed to take or pass.

(c) Upon learning or in any way becoming aware that an applicant who is performing cosmetology services in their salon pursuant to Rule 61G5-18.0055, F.A.C., has either failed to take the next available licensure examination immediately following the licensure examination which the applicant failed to pass, immediately cease to permit the applicant to further perform cosmetology services until the applicant provides to the cosmetology salon license holder proof of having been issued a cosmetology license by the Department.

(d) Ensure that all cosmetology services performed by the applicant in the salon are performed in accordance with the conditions as set forth in Rule 61G5-18.0055, F.A.C.

(e) Display in a conspicuous place at the cosmetology salon location in which the applicant performs cosmetology services under Rule 61G5-18.0055 a copy of the completed application for licensure by examination

submitted to the Department by the applicant, and a copy of the completed application for reexamination submitted to the Department by the applicant if such reexamination is required under Rule 61G5-18.0055, F.A.C.

(2) Holders of a cosmetology or specialty salon license who wish to permit an applicant for registration as a specialist to perform specialty services in their salon pursuant to Rule 61G5-29.004, F.A.C., or who wish to permit applicants for registration as a hair braider or hair wrapper to perform hair braiding or hair wrapping services in their salon pursuant to Rule 61G5-31.006, shall:

(a) prior to permitting an applicant to perform any specialty services or hair braiding or hair wrapping services in their salon, obtain from the applicant a copy of the completed application for registration submitted to the Department by the applicant;

(b) upon learning or in any way becoming aware that an applicant who is performing specialty services in their salon pursuant to Rule 61G5-29.004, F.A.C., or performing hair braiding or hair wrapping services in their salon pursuant to Rule 61G5-31.006, F.A.C., has been notified that his or her application is incomplete, or has been determined by the Board to be not qualified for registration as a specialist, shall immediately cease to permit the applicant to further perform specialty services;

(c) ensure that all specialty services performed by the applicant in the salon are performed in accordance with the conditions as set forth in Rule 61G5-29.004, F.A.C., and all other applicable laws and Rules of the Board;

(d) ensure that all hair braiding and hair wrapping services performed by the applicant in the salon are performed in accordance with all applicable laws and Rules of the Board;

(e) display in a conspicuous place at the cosmetology or specialty salon location in which the applicant performs specialty services pursuant to Rule 61G5-29.004, F.A.C., or hair braiding or hair wrapping services pursuant to Rule 61G5-31.006, a copy of the completed application for registration as a specialist or application for registration as a hair braider or hair wrapper submitted to the Department by the applicant.

Specific Authority 477.016, 477.019(4), 477.0201(6), 477.025(2) FS. Law Implemented 477.019(4), 477.0201(6), 477.025(2) FS. History—New 10-18-87, Amended 5-2-91, Formerly 21F-20.008, Amended 11-11-96, 12-21-97, 11-25-98.

61G5-20.010 Mobile Salons.

- (1) The operation of all mobile cosmetology salons shall meet and at all times remain in compliance with all local laws and ordinances regulating business establishments in all areas in which the mobile salon operates, with all applicable requirements of the Americans with Disabilities Act relating to accommodations for persons with disabilities, and with all applicable OSHA requirements.
- (2) Each mobile salon shall meet and at all times remain in compliance with the requirements of this rule, all licensure and operating requirements specified in Chapters 455 and 477, F.S., and all other rules of the Board and the Department which apply to cosmetology salons at fixed locations except to the extent those rules of the Board conflict with this rule.
- (3) To facilitate inspections by the Department:
- (a) Prior to the beginning of each month, each mobile salon license holder shall file with the Board a written monthly itinerary which lists the locations where and the dates and hours when the mobile salon will be operating.
- (b) The salon name and salon license number shall be in lettering at least five inches in height and shall be visibly displayed and clearly legible on at least two exterior sides of each mobile salon.
- (c) If a mobile salon is in a motor vehicle, the vehicle's identification number shall be included on the mobile salon's application for licensure and shall also be listed on the mobile salon's monthly itinerary required in paragraph (a) of this subsection.
- (d) Each mobile salon shall have a telephone or other means of telecommunication by which it can be contacted by the Department personnel. The salon's telephone number shall be included on the mobile salon's application for licensure and shall also be listed on the mobile salon's monthly itinerary required in paragraph (a) of this subsection.
- (e) Each salon shall be operated only at the times and places specified in its monthly itinerary.
- (f) Each mobile salon license holder shall maintain a permanent business address in the inspection area of the local district office at which records of appointments, itineraries, license numbers of employees, and vehicle identification numbers of the license holder's mobile salon shall be kept and made available for verification purposes by Department personnel, and at which correspondence from the Department can be received. Post Office box or private mail box addresses may not be used for these purposes.
- (4) Due to the inherent problems of providing water and sewage service to mobile salons, the following requirements shall apply:
- (a) Each mobile salon shall be equipped with a functional restroom which includes a self-contained,

flush chemical

toilet with a holding tank. The restroom, shall also be in substantial compliance with the toilet and lavatory

requirements specified in Rule 61G5-20.002, F.A.C.

(b) Each mobile salon shall have storage capacity for at least 35 gallons of clean water for each cosmetologist working

in the mobile salon and a total storage capacity for waste water equal to or greater than the mobile salon's total

capacity for clean water.

(c) Operation of a mobile salon shall promptly cease:

1. When the mobile salon's clean water supply is depleted or so diminished that further cosmetology service cannot be completed;

2. When the mobile salon's waste water storage capacity is reached;

3. When the mobile salon's restroom is in need of servicing.

(d) No mobile salon shall operate or resume operation unless it has a sufficient amount of clean water as well as waste

water capacity necessary for completing all cosmetology services undertaken and its restroom is functional.

(e) In disposing of sewage and waste water, each mobile salon shall comply with applicable state and local

environmental and sanitation regulations.

(5) No cosmetology services shall be performed and no patrons shall remain within a mobile salon while it is in

motion.

(6) Applicants for licensure of a mobile salon shall be subject to and shall pay the same fees which licensed salons at

fixed locations are subject to.

Specific Authority 477.016, 477.025(2) FS. Law Implemented 477.025, 477.025(10) FS. History—New 2-10-94,

Amended 12-27-95, 11-25-98.

61G5-31.002 Hair Braiding, Hair Wrapping, and Body Wrapping; Registration Requirements, Practice Outside of Licensed Salon.

(1) Only those individuals who are licensed to engage in the practice of cosmetology in the State of Florida, or who are registered to engage in the practice of hair braiding in the State of Florida shall engage in the practice of hair braiding or perform hair braiding services in the State of Florida.

(2) Only those individuals who are licensed to engage in the practice of cosmetology in the State of Florida, or who are registered to engage in the practice of hair wrapping in the State of Florida shall engage in the practice of hair wrapping or perform hair wrapping services in the State of Florida.

(3) Registration as a hair braider shall not authorize a registrant to practice hair wrapping. Registration as a hair wrapper shall not authorize a registrant to practice hair braiding.

(4) Only those individuals who are licensed to engage in the practice of cosmetology in the State of Florida, or who are registered to engage in the practice of body wrapping in the State of Florida shall engage in the practice of body wrapping or performed body wrapping services in the State of Florida.

(5) Whenever either hair braiding, hair wrapping, or body wrapping services are performed in a

location other than a licensed cosmetology or specialty salon, all implements used in connection with the performance of the services shall be of a disposable nature; or shall be sanitized in a disinfectant approved for hospital use or approved by the Environmental Protection Agency. Whenever either hair braiding, hair wrapping, or body wrapping services are performed in a licensed cosmetology or specialty salon, all laws and rules of the Board concerning the operation of the cosmetology or specialty salon, including all sanitary and disinfectant requirements, shall be observed and complied with by individuals performing hair braiding, hair wrapping, or body wrapping services.

Specific Authority 477.0132, 477.016 FS. Law Implemented 477.0132, 477.029 FS. History—New 2-1-95, Amended 11-25-98, 9-6-00.

61G5-31.003 Hair Braiding, Hair Wrapping, and Body Wrapping Registration.

(1) All persons desiring to become registered to practice hair braiding shall apply for registration to the Department in writing upon forms prepared and furnished by the Department, shall pay the registration fee as set forth in Chapter 61G5-24, F.A.C., and shall provide satisfactory proof of their successful completion of a two-day 16-hour Board approved hair braiding course.

(2) All persons desiring to become registered to practice hair wrapping shall apply for registration to the Department in writing upon forms prepared and furnished by the Department, shall pay the registration fee as set forth in Chapter 61G5-24, F.A.C., and shall provide satisfactory proof of their successful completion of a one-day 6-hour Board approved hair wrapping course.

(3) All persons desiring to become registered to practice body wrapping shall apply for registration to the Department, shall pay the registration fee as set forth in Chapter 61G5-24, F.A.C., and shall provide satisfactory proof of their successful completion of a two-day 12-hour Board approved body wrapping course as set forth in Rule 61G5-31.004, F.A.C.

(4) Satisfactory proof of successful completion of the required hair braiding course, hair wrapping course, or body wrapping course shall consist of the original or a legible copy of the certificate of completion supplied to the applicant by the provider of the course indicating the provider's name, the student name, the dates of the course, and the total number of hours successfully completed.

(5) All persons who have applied for registration as a hair braider, hair wrapper, or body wrapper shall retain a copy of all materials submitted in connection with their application, including the completed application, proof of payment of all applicable fees, and satisfactory proof of their successful completion of a Board approved hair braider, hair wrapper, or body wrapper course, until they are issued a certificate of registration or notified that their application has been denied.

Specific Authority 477.0132, 477.016, 477.026(1)(f) FS. Law Implemented 477.0132, 477.026(1)(f), 477.029 FS. History—New 2-1-95, Amended 11-25-98, 9-6-00.

61G5-31.004 Hair Braiding and Hair Wrapping Course Requirements.

(1) All hair braiding courses taught for purposes of qualifying an individual for initial registration as a hair braider shall be a two-day, 16-hour course; and, shall be approved by the Board prior to the course being taught for registration qualification purposes. To be considered for approval by the Board, the course shall consist of the following:

(a) 5 hours of instruction regarding HIV/AIDS and other communicable diseases. At the conclusion of this instruction a student shall be able to understand:

1. The causes of HIV/AIDS, hepatitis, tuberculosis, and other communicable diseases and how these diseases are spread;

2. The dangers associated with these diseases; and

3. How to avoid contamination from the diseases in the practice of hair braiding.

(b) 5 hours of instruction regarding sanitation and sterilization. At the conclusion of this instruction

a student shall be able to understand:

1. Universal sanitation and sterilization precautions;
2. How to distinguish between disinfectants and antiseptics; and
3. How to sanitize hands and disinfect tools used in the practice of hair braiding.

(c) 4 hours of instruction regarding disorders and diseases of the scalp. At the conclusion of this instruction a student shall be able to understand:

1. Disorders and diseases of the scalp and how to distinguish between them; and
2. When hair braiding services can be performed on a client with disorders or diseases of the scalp.

(d) 2 hours of instruction regarding the laws and rules of the Board which affect and govern the practice of hair braiding. At the conclusion of this instruction a student shall be able to understand:

1. The laws and rules of the Board that protect the health, safety, and welfare of the consumer;
2. The laws and rules of the Board that determine where and when an individual may legally practice hair braiding;

practice hair braiding;

3. The function of the Board of Cosmetology, how its members are appointed, and their duties;

4. The laws and rules of the Board which specify prohibited conduct, and the penalties for failure to follow the laws and rules; and

5. The dates, fees, and requirements for renewal of a hair braiding registration.

(2) All hair wrapping courses taught for purposes of qualifying an individual for initial registration as a hair wrapper shall be a one-day, 6-hour course; and, shall be approved by the Board prior to the course being taught for registration qualification purposes. To be considered for approval by the Board, the course shall consist of the following:

(a) Two (2) hours of instruction regarding HIV/AIDS and other communicable diseases. At the conclusion of this instruction, a student shall be able to understand:

1. The causes of HIV/AIDS, hepatitis, tuberculosis, and other communicable diseases and how these diseases are spread;

2. The dangers associated with these diseases; and

3. How to avoid contamination from the diseases in the practice of hair wrapping.

(b) Two (2) hours of instruction regarding sanitation and sterilization. At the conclusion of this instruction, a student shall be able to understand:

1. Universal sanitation and sterilization precautions;

2. How to distinguish between disinfectants and antiseptics; and

3. How to sanitize hands and disinfect tools used in the practice of hair wrapping.

(c) One (1) hour of instruction regarding disorders and diseases of the scalp. At the conclusion of this instruction, a student shall be able to understand:

1. disorders and diseases of the scalp and how to distinguish between them; and

2. when hair wrapping services can be performed on a patron with disorders or diseases of the scalp.

(d) One (1) hour of instruction regarding the laws and rules of the Board which affect and govern the practice of hair wrapping. At the conclusion of this instruction, a student shall be able to understand:

1. The laws and rules of the Board that protect the health, safety, and welfare of the consumer;

2. The laws and rules of the Board that determine where and when an individual may legally practice hair wrapping;

practice hair wrapping;

3. The function of the Board of Cosmetology, how its members are appointed, and their duties;

4. The laws and rules of the Board which specify prohibited conduct, and the penalties for failure to follow the laws and rules;

5. The dates, fees, and requirements for renewal of a hair wrapping registration.

(3) All body wrapping courses taught for purposes of qualifying an individual for initial registration as a body wrapper shall be a two-day, 12-hour course; and, shall be approved by the Board prior to the course being taught for registration qualification purposes. To be considered for approval by the Board, the course shall consist of the following:

(a) Three (3) hours of instruction regarding HIV/AIDS and other communicable diseases. At the conclusion of this instruction, a student shall be able to understand:

1. The causes of HIV/AIDS, hepatitis, tuberculosis, and other communicable diseases and how these diseases are spread;
2. The dangers associated with these diseases; and,
3. How to avoid contamination from the diseases in the practice of body wrapping.

(b) Four (4) hours of instruction regarding sanitation and sterilization. At the conclusion of this instruction, a student shall be able to understand:

1. Universal sanitation and sterilization precautions;
2. How to distinguish between disinfectants and antiseptics; and,
3. How to sanitize hands and disinfect tools used in the practice of body wrapping.

(c) Four (4) hour of instruction regarding disorders and diseases of the skin. At the conclusion of this instruction, a student shall be able to understand:

1. Disorders and diseases of the skin and how to distinguish between them; and,
2. When skin wrapping services can be performed on a patron with disorders or diseases of the skin.

(d) One (1) hour of instruction regarding laws and rules of the Board which affecting and govern the practice of body wrapping. At the conclusion of this instruction, a student shall be able to understand:

1. The laws and rules of the Board that protect the health, safety, and welfare of the consumer;
2. The laws and rules of the Board that determine where and when an individual may legally practice body wrapping;
3. The function of the Board of Cosmetology, how its members are appointed, and their duties;
4. The laws and rules of the Board which specify prohibited conduct, and the penalties for failure to follow the laws and rules;
5. The dates, fees, and requirements for renewal of a body wrapping registration.

(4) All proposed hair braiding, hair wrapping, or body wrapping courses must be submitted for presentation to the Board no later than 30 days prior to the next regularly scheduled meeting of the Board at which the proposed course is to be considered for approval. No hair braiding, hair wrapping, or body wrapping course may be taught for credit towards the initial hair braiding, hair wrapping, or body wrapping registration requirements until it has been reviewed and approved by the Board.

(5) All providers of hair braiding, hair wrapping, and body wrapping courses shall provide to all individuals who successfully complete the course a certificate of completion which shall indicate the title of the course completed, the provider's name, the student name, the date of the course, and the total number of hours successfully completed.

Specific Authority 477.0132, 477.016 FS., Chapter 99-251, Laws of Florida. Law Implemented 477.0132 FS., Chapter 99-251, Laws of Florida. History—New 2-1-95, Amended 4-8-96, 11-25-98, 12-20-99.

61G5-31.005 Hair Braiding, Hair Wrapping, and Body Wrapping Term of Registration, Registration Renewal.

(1) All hair braiding, hair wrapping, and body wrapping registrations shall be valid for a period of two years or until the end of the biennial licensure renewal cycle in which they are first issued, whichever occurs first. The biennial licensure renewal cycle for all hair braiding, hair wrapping, and body wrapping registrations shall coincide with the biennial licensure renewal cycle used for the renewal of cosmetology licenses and specialty registrations.

(2) At the time of registration renewal, all hair braiding, hair wrapping, and body wrapping registrants shall pay all applicable renewal fees and charges as provided in Chapter 61G5-24, F.A.C. Prior to the expiration of their hair braider, hair wrapper, or body wrapper registration, all hair braiding, hair wrapping, and body wrapping registrants shall complete a Board approved HIV/AIDS training course as provided in Section 455.2228, F.S. All HIV/AIDS training courses shall comply with the requirements as set forth in Rule 61G5-18.011, F.A.C.

Specific Authority 455.203(1), 455.2228, 477.016 FS. Law Implemented 455.203(1), 455.2228, 477.029 FS. History—New 11-25-98, Amended 9-6-00.

61G5-31.006 Practice of Hair Braiding, Hair Wrapping, and Body Wrapping Pending Approval of Registration.

(1) An applicant for registration as a hair braider shall be eligible to practice hair braiding, and an applicant for registration as a hair wrapper shall be eligible to practice hair wrapping, and an applicant for registration as a body wrapper shall be eligible to practice body wrapping, pending the approval of his or her application for registration provided the individual has previously submitted the following to the Department:

(a) A properly completed registration application;

(b) Payment of all applicable fees for initial registration as set forth in Chapter 61G5-24, F.A.C.; and

(c) Proof of successful completion of a Board approved hair braiding, hair wrapping, or body wrapping course as defined in Rule 61G5-31.004, F.A.C.

(2) Upon notification that his or her application is complete, an applicant for registration as a hair braider, hair wrapper or body wrapper is eligible to practice hair braiding, hair wrapping and body wrapping pending the approval of his or her application for registration.

(3) Applicants wishing to perform hair braiding, hair wrapping, or body wrapping services under this exception in a licensed cosmetology or specialty salon shall, prior to beginning the performance of hair braiding, hair wrapping, or body wrapping services in the salon, provide to the cosmetology or specialty salon license holder or his or her representative a copy of the completed application for registration as a hair braider, hair wrapper, or body wrapper submitted to the Department by the applicant.

Specific Authority 477.0132, 477.016 FS. Law Implemented 477.0132, 477.029 FS. History—New 11-25-98, Amended 9-6-00.

"

References and Resources

Center for Disease Control and Prevention <http://www.cdc.gov/>

<http://www.epa.gov>

Food and Drug Administration <http://www.fda.gov>

Milady's Standard Cosmetology (2008) Thomson Delmar Learning

Milady's Standard Fundamentals for Estheticians, 9th Edition (2004) Delmar Learning

Nail Structure and Product Chemistry, Second Edition (2005) Thomson Delmar Learning

Milady's Standard Nail Technology, 5th Edition (2007) Thomas Delmar Learning

Florida State Board of Cosmetology: Florida Department of Business and Professional Regulation