

5. If applicant is a corporation the full names, residence addresses, dates and places of birth of each major officer and each stockholder, the names and addresses of the registered agent and the address of the principal office. (Use additional sheets if necessary)

a. Name _____

Street Address _____

Number Street Name
Municipality _____ Zip _____ - _____

1. Have you ever been arrested or convicted of a crime? Yes _____ No _____

2. If your answer is "YES" please give the date of the arrest, the crime or charge involved and the disposition thereof. (Use additional sheets if needed)

b. Name _____

Street Address _____

Number Street Name
Municipality _____ Zip _____ - _____

1. Have you ever been arrested or convicted of a crime? Yes _____ No _____

2. If your answer is "YES" please give the date of the arrest, the crime or charge involved and the disposition thereof. (Use additional sheets as needed)

6. Name and address of any and all previous locations the applicant has owned, operated or been employed by that provided massage therapy or similar services. (Insert N/A if not applicable)

Name _____

Street Address _____

Number Street
Municipality _____ Zip _____ - _____

7. Has the applicant ever been denied a massage therapy license? Yes _____ No _____
If the answer to this question is "YES" answer the following:

a. Name of City/.Borough/Township of denial. _____

b. Date of Denial _____

c. Reason for Denial _____

8. Has any corporation, partnership or individual mentioned in this application, other than the applicant, been denied a massage therapy license? Yes ____ No ____ . If the answer to this question is "YES" answer the following

a. Name of City/.Borough/Township of denial. _____

b. Date of Denial _____

c. Reason for Denial _____

9. Actual address where the license is to be used (sited premises).

Street Address _____

Number _____ Street Name _____

Municipality _____ Zip _____ - _____

Telephone number of business (_____) _____ - _____

Area Exchange Number

10. Does the applicant own the building? _____ Yes _____ No
If yes is there a mortgage on the building? _____ Yes _____ No
Does the applicant lease the building? _____ Yes _____ No

11. If there is a mortgage on the property, answer question 11a. If the licensed premise is leased, answer question 11b.

a. Mortgagee (Holder of Mortgage):

Street address _____

Number _____ Street Name _____

Municipality _____ State _____ Zip _____ - _____

b. Landlord (Holder of Lease):

Street address _____

Number _____ Street Name _____

Municipality _____ State _____ Zip _____ - _____

12. If mailing address is different than the actual address given above, provide the mailing address: (Insert N/A if not applicable).

Street Address _____

Number _____ Street Name _____

P.O. Box # _____ Municipality _____ State _____

Zip _____ - _____ Telephone (_____) _____ - _____

13. Name and address of the accredited school that you attended. (Applicant must show documentary proof of satisfactory completion of 500 hours course study in massage therapy.)

School Name _____

Street Address _____
Number Street Name

Municipality _____ State _____ Zip _____ - _____

Dates attended: From _____ to _____.

14. List the name and address of all nationally recognized massage therapy associations that you are a member of. (Documented proof must be included with the application.)

Association Name _____

Street Address _____
Number Street Name

Municipality _____ State _____ Zip _____ - _____

15. Name and address of the licensed physician of the State of New Jersey establishing that the applicant is free from contagious and communicable diseases within 30 days of the date of application. (Documented proof must be included with the application.)

Physician's Name _____

Street Address _____
Number Street Name

Municipality _____ State _____ Zip _____ - _____

Telephone (_____) _____ - _____

16. Name and address of the applicant's liability insurance provider. (Documented proof must be included with the application.)

Insurance Carrier's Name _____

Street Address _____
Number Street Name

Municipality _____ State _____ Zip _____ - _____

Telephone (_____) _____ - _____

17. Have you made application to the Carlstadt Police Department and been photographed and fingerprinted?

Yes - Date of Application: _____ No – Anticipated Date of Application: _____

18. Has the premises identified in number 9 above, been inspected by the Carlstadt Board of Health?

Yes _____ Date inspected: _____
No _____ Date scheduled for an inspection to be made: _____

I hereby certify that the statements made in this application are true to the best of my knowledge and ability and that if any of the statements made herein are willfully false I am subject to punishment.

Signature of Applicant

Date

FOR OFFICIAL BOROUGH USE

- ____ MUNICIPAL FEE \$: 250.00 RECEIVED
- ____ EVIDENCE OF 500 HOURS OF TRAINING
- ____ PROOF OF MEMBERSHIP IN NATIONAL ASSOCIATION
- ____ PHYSICIAN'S CERTIFICATE (within 30 days of date of application)
- ____ PROOF OF ADEQUATE LIABILITY INSURANCE COVERAGE

DEPARTMENTAL REVIEWS/INSPECTIONS:

- ____ CARLSTADT POLICE DEPARTMENT
- ____ CARLSTADT BOARD OF HEALTH INSPECTION REPORT
- ____ ZONING DEPARTMENT

APPROVED BY MAYOR AND COUNCIL:
RESOLUTION NO. _____ DATED _____

LICENSE ISSUED: _____

EXPIRATION DATE: _____