

**BOROUGH OF CARLSTADT**

**MASSAGE THERAPY APPLICATION**

**Technician/Practitioner License**

DATE APPLICATION FILED: \_\_\_\_\_

THIS APPLICATION IS FOR:

- |  |            |
|--|------------|
| _____ A New Massage Technician/Practitioner License  | FEE: \$100 |
| _____ Renewal of Carlstadt issued Massage Technician/Practitioner License<br>(expired more than 30 days) | FEE: \$100 |
| _____ Renewal of Carlstadt issued Massage Technician/Practitioner License<br>(current)                   | FEE: \$ 25 |
| _____ Amendment of Application on File   | FEE: \$ 25 |
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1. Applicant's name \_\_\_\_\_  
Street Address \_\_\_\_\_  
  Number  Street Name  
Municipality \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_  
Telephone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

2. Applicant's date and place of birth.  
Date of Birth \_\_\_\_\_  
Place of Birth \_\_\_\_\_ and \_\_\_\_\_  
  City  State

3. Name as it does or will appear on the license certificate (not "Trade" Name):      License  
must be held by an Individual (last name, first, middle initial)

\_\_\_\_\_ (Last Name, First, Middle Initial or Corporate Name)

Date of Issuance of previous License issued by the Borough of Carlstadt: \_\_\_\_\_

4. Have you ever been arrested or convicted of a crime? Yes \_\_\_\_\_ No \_\_\_\_\_  
If your answer is "YES" please provide the date of the arrest, the crime or charge involved and the disposition thereof. (Use additional sheets if needed)

\_\_\_\_\_  
\_\_\_\_\_

5. 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.) Use additional sheets if necessary.

Name \_\_\_\_\_

Street Address \_\_\_\_\_  
Number Street

Municipality \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_

6. 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 \_\_\_\_\_

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

Name of Establishment \_\_\_\_\_

Date license issued to Establishment by Borough of Carlstadt: \_\_\_\_\_

Street Address \_\_\_\_\_  
Number Street Name

Municipality \_\_\_\_\_ Zip \_\_\_\_\_ - \_\_\_\_\_

Telephone number of business (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Area Exchange Number

8. If mailing address of establishment 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 (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

9. 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 (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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

\_\_\_\_\_ Yes - Date of Application: \_\_\_\_\_

\_\_\_\_\_ No - Anticipated Date of Application: \_\_\_\_\_

11. New Jersey Massage Therapy License No. \_\_\_\_\_

Expiration Date: \_\_\_\_\_ (Copy is required to be attached.)

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

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FOR OFFICIAL BOROUGH USE

\_\_\_ MUNICIPAL FEE \_\_\_ \$ 100.00 RECEIVED  
\_\_\_ \$ 25.00 RECEIVED - RENEWAL

\_\_\_ COPY OF PREVIOUS CARLSTADT ISSUED MASSAGE THERAPY LICENSE

\_\_\_ COPY OF CURRENT STATE OF NJ MASSAGE THERAPY LICENSE

\_\_\_ PROOF OF ADEQUATE LIABILITY INSURANCE COVERAGE

\_\_\_ COPY OF STATE ISSUED ID

DEPARTMENTAL REVIEWS/INSPECTIONS:

\_\_\_ CARLSTADT POLICE DEPARTMENT

\_\_\_ CARLSTADT BOARD OF HEALTH

\_\_\_ ZONING DEPARTMENT

APPROVED BY MAYOR AND COUNCIL:

RESOLUTION NO. \_\_\_\_\_ DATED \_\_\_\_\_

INITIAL LICENSE ISSUED: \_\_\_\_\_

RENEWAL LICENSE ISSUED: \_\_\_\_\_

EXPIRATION DATE: \_\_\_\_\_