MASSAGE THERAPY APPLICATION

Establishment License

DATE APPLICATION FILED: _____ FEE: $250.00

THIS APPLICATION IS FOR:

_____ A New Massage Establishment

_____ Renewal of a Message Establishment License

_____ Change in Corporate Structure

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1. Application is made on behalf of: _____ (*Insert appropriate number*)

   1 = An Individual
   2 = Business Corporation
   3 = A Partnership
   4 = Limited Partnership

2. If applicant is an individual the applicant's name, residential address and telephone number.

   Applicant's name _____

   Street Address _____
   Number Street Name

   Municipality _____State _____ Zip _____- ____

   Telephone (_____) _____-_____

3. If applicant is an individual the applicant's date and place of birth.

   Date of Birth _____

   Place of Birth _____ and _____
   City State

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

   _____
   (Last Name, First, Middle Initial or Corporate Name)

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: _____