

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)

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 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 _____

10. 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 _____ - _____

11. 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 (_____) _____ - _____

12. 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 (_____) _____ - _____

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

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

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 \$: 100.00 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
- ___ ZONING DEPARTMENT

APPROVED BY MAYOR AND COUNCIL:

RESOLUTION NO. _____ DATED _____

LICENSE ISSUED: _____

EXPIRATION DATE: _____