# RENEWAL
# APPLICATION FOR
# MASSAGE THERAPIST LICENSE
# THERAPEUTIC MASSAGE BUSINESS LICENSE

City of Inver Grove Heights
8150 Barbara Ave, Inver Grove Heights, MN 55077 (651) 450-2500 Fax (651) 450-2502
www.invergroveheights.org

All persons performing massage in the City of Inver Grove Heights need to be licensed. If you previously have applied and were approved for performing massage in the City of Inver Grove Heights you will need to complete the following for a renewal license.

Check all that apply:

☐ Renewal Massage Therapist License (Individual)

☐ Renewal Therapeutic Massage Business License

***This form must be completed by each of the following with a colored copy of driver's license or government issued photo ID attached.***

**Part 1 ALL APPLICANTS COMPLETE PART 1**

**PERSONAL INFORMATION**

| Your Name (Full First, Middle, Last): | Place of Birth (City, State): | Date of Birth: |
|---|---|---|
| | | |

| Height: | Weight: | Eye Color: | Hair color: |
|---|---|---|---|
| | | | |

| Residential Street Address: | City: | State: | Zip Code: |
|---|---|---|---|
| | | | |

| Phone Number: | U.S. Citizen: _____Yes _____No | If non U.S. citizen, list home country and attach proof of eligibility to work in U.S.: |
|---|---|---|
| | | |

Email Address:

| Social Security Number (SSN): | Individual Tax Identification Number (ITIN) if applicable: |
|---|---|
| | |

**Criminal History, Arrest Records, Warrant Information, and Other Relevant Records – (please copy form as needed)**

Have you ever been convicted of any felony crimes or ordinance violations, other than traffic offenses since your last application?

_____Yes _____ No

If yes, list – *Attach additional sheets if necessary*

| Offense | Fine/Penalty | Location (City/State) | Date of Occurrence: |
|---|---|---|---|
| | | | |

Have you been convicted of violation of any federal, state, or local law relating to the operation of any business requiring a license since your last application?

_____Yes _____No

If yes, list – *Attach additional sheets if necessary*

| Offense | Fine/Penalty | Location (City/State) | Date of Occurrence: |
|---|---|---|---|
| | | | |

**CERTIFICATE OF PROFESSIONAL LIABILITY**

Are you currently insured for professional liability to practice massage? ____ YES ____NO

If yes, list insured information- Attached Certificate of Profession Liability with $1,000,000.00 insurance coverage

| Insurer | Phone Number | Street Address | State | Zip |
|---|---|---|---|---|
| | | | | |

**ADDITIONAL INFORMATION**

Additional information you want to include that was not required in Part 1:

**PART 2 ONLY MASSAGE THERAPIST LICENSE APPLICANTS COMPLETE PART 2**

**THERAPEUTIC MASSAGE BUSINESS INFORMATION**

| | | |
|---|---|---|
| Therapeutic Massage Business Name (DBA) where applying to be an Individual Therapist: | | |
| Street Address of Licensed Premises: | | Business Contact (first and last name): |
| Zip Code: | Business Phone: | Contact's Phone Number: |

**INDIVIDUAL MASSAGE THERAPIST LICENSE HISTORY**

Are you currently licensed as a Massage Therapist in another city? _____Yes _____No

If yes, list City's information – *(please copy form as needed)*

| City | Street Address | State | Zip |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Have you ever been denied or rejected for an individual Massage Therapist License since your last application? _____Yes _____No

If yes, list – *(please copy form as needed)*

| City | Street Address | State | Zip |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Have you as an individual or as part of a corporation, partnership, association, enterprise, business or firm ever had a Massage Therapist License revoked or suspended within the last (5) years of this application? _____Yes _____No

If yes, list – *(please copy form as needed)*

| City | Street Address | State | Zip |
|---|---|---|---|
| | | | |
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| | | | |
| | | | |

Have you ever owned and/or operated a Therapeutic Massage Business since your last application? _____Yes _____ No

If yes, list – *(please copy form as needed)*

| Employer & Occupation | Phone Number | Street Address | City/State | Zip | From (MM/YY) | To (MM/YY) |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

**PART 3 ONLY THERAPEUTIC MASSAGE BUSINESS LICENSE APPLICANTS COMPLETE PART 3**

**TYPE OF THERAPEUTIC MASSAGE BUSINESS**
***Circle one***

| | | |
|---|---|---|
| **Individual/Sole Proprietorship** | **Business/Firm** | **Partnership** |
| **Corporation** | **Limited Liability Company** | **Other Entities** |

**ADDITIONAL REQUIREMENTS FOR THE FOLLOWING THERAPEUTIC MASSAGE BUSINESS APPLICANTS**

**Partnerships**

1. **All partners must complete Part 1 of application in conjunction with one (1) partner completing entire application.**
2. Managing Partners need to be designated:
   *(please copy form as needed)*

| Managing Partner (First/Last) | Title |
|---|---|
| | |
| | |
| | |

3. Each Partner (General and Limited) shall have their interest disclosed:
   *(please copy form as needed)*

| Partner who control an Interest (First/Last) | Percent of Interest |
|---|---|
| | |
| | |
| | |

4. Attach:
   1. A true copy of the Partnership Agreement and a copy
   2. A true copy of trade name under MN Statute §333.02 (Certified by the Clerk of District Court)

**Corporations and other Organizations or Entities**

| 1. Corporation/Association/Other Organization Name | 2. State of Incorporation (Must be authorized to do business in Minnesota) |
|---|---|
| | |

3. Attach:
   1. A true copy of the certificate of incorporation and if a Foreign corporation a certificate of authority as described in MN Statute §303.02
   2. Articles of Incorporation of Association Agreement
   3. By-laws of the Corporation
4. **All persons (General Manager, corporate officers, proprietor and other persons in charge) must complete Part 1 of application in conjunction with one (1) person completing entire application.**

**NAME/ADDRESS OF THERAPEUTIC MASSAGE BUSINESS**

Therapeutic Massage Business Name (DBA):

| | | |
|---|---|---|
| Street Address of Premises: | | Business Contact (first and last name): |
| Zip Code: | Business Phone: | Contact's Phone Number: |
| Floor Number (if applicable): | Suite Number (if applicable): | Business Email Address & Website Address: |

**MASSAGE THERAPIST BUSINESS LICENSE HISTORY**

Is the corporation, partnership, association, enterprise, business or firm currently licensed as a Massage Therapist Business in another city?
_____Yes _____No

If yes, list City's information – *(please copy form as needed)*

| City | Street Address | State | Zip |
|---|---|---|---|
| | | | |
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**PART 3 CONTINUED**
**ONLY THERAPEUTIC MASSAGE BUSINESS LICENSE APPLICANTS COMPLETE PART 3**

Has the corporation, partnership, association, enterprise, business or firm ever been denied or rejected for a Therapeutic Massage Business License since your last application? _____Yes _____No

If yes, list – *(please copy form as needed)*

| City | Street Address | State | Zip |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Has the corporation, partnership, association, enterprise, business or firm ever had a Therapeutic Massage Business License revoked or suspended within the last (5) years of this application? _____Yes _____No

If yes, list – *(please copy form as needed)*

| City | Street Address | State | Zip |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**BUSINESS PREMISES INFORMATION**

**Business premises is owned by**

| Owner (First/Last Name) | Phone Number | Street Address | State | Zip |
|---|---|---|---|---|
| | | | | |

Is the business premises in the construction planning phase or currently under construction? _____Yes

_____No (the premises is already constructed)

If business premises is preexisting will there be any building changes/modifications to your work space? _____Yes _____No

If yes, explain the scope of work;

_____

_____

Are the business premises design plans on file with the city's building and inspections department? _____Yes _____No

If No, *Attach plan/sketch showing dimensions, location of buildings, street access, parking facilities configuration, interior dimension & total floor space.*

Are there any real estate taxes, personal property taxes, special assessments, or other financial claims delinquent or unpaid for the premises to be licensed? If yes, give details:

_____

**PROFESSIONAL LIABILITY**

Are you currently insured for professional liability to practice massage? _____Yes _____No

If yes, list insurer information – ***Attach certificate of professional liability with $1,000,000.00 limits***

| Insurer | Phone Number | Street Address | State | Zip |
|---|---|---|---|---|
| | | | | |

**LIST OF THERAPISTS THAT WILL BE WORKING AT MASSAGE THERAPIST BUSINESS – (please copy form as needed)**

| Name (First/Last) | Contact number | Address |
|---|---|---|
| | | |
| | | |
| | | |

**PART 4 ALL APPLICANTS COMPLETE PART 4**

**DATA PRIVACY ADVISORY**

The Minnesota Data Practices Act requires that we inform you of your rights about the private data we are requesting on this form. As part of this application, you are asked to provide private and/or confidential information about yourself that will be used to check driving history, criminal history, arrest records, warrant information, and other relevant records. You may refuse to provide this information. However, should you refuse; our investigation cannot be completed and will result in your application not being processed. The information you provide is public and will be used by the City of Inver Grove Heights Police Department, Licensing Department, the Inver Grove Heights City Council, and the general public.

**This AUTHORIZATION FOR RELEASE OF INFORMATION will expire six (6) months from the date it was signed.**
**I HAVE READ AND UNDERSTAND THE ABOVE DATA PRACTICES ADVISORY**

**Signature**_____ **Date**_____

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I request and authorize you to release any and all information concerning me to the City of Inver Grove Heights to receive any and all information concerning me.

This request is related to an investigation by the Inver Grove Heights Police Department and is required for this application.

I understand my rights concerning the release of information pursuant to the Minnesota Data Practices Act and authorize this release of information to the City of Inver Grove Heights and its employees.

This Authorization is valid for six (6) months from the date it was signed.

**Please Print**

| | | | |
|---|---|---|---|
| Your Name (Full First, Middle, Last): | | Date of Birth (MM/DD/YY): | |
| Address: | City: | State: | Zip Code: |
| Signature: _____ | | Date: | |

**PART 5 ALL APPLICANTS COMPLETE PART 5**

**VERIFICATION**

**The data you furnish on this application will be used by the City of Inver Grove Heights to assess your qualifications for licensure. Disclosure of this information is voluntary. You are not legally required to provide this data; however, if you fail to do so, the City of Inver Grove Heights may be unable to process this application. Disclosure of your Social Security number, Minnesota Tax ID Number, or Individual Tax ID Number is required by Minnesota Statutes 270C.72 and your Social Security number may be requested by and released to the Department of Revenue. Upon submission of this application, all information except your Social Security Number will be public information pursuant to Minnesota Statutes, Chapter 13.**

**I have no intention or agreement to transfer the license to another person, or to allow any other person or entity to operate under the authority of the license.**

**I understand that by submitting this application as an individual and operating a massage business in the City of Inver Grove Heights, I hereby consent to allow the appropriate City personnel, or any authorized representative or agents, to inspect the licensed premises for the purpose of ensuring compliance with the law, at any time the business is occupied and/or open for business. I also understand that a denial of permission for such a lawful inspection of the premises is a violation of the license provisions.**

**I have received from the City of Inver Grove Heights a copy of the ordinance that regulates the activity for which I am applying for licensure and I agree to familiarize myself with the provisions of said ordinance.**

**I will strictly comply with all the laws of the State of Minnesota governing the rules and regulations of operating a massage business and all ordinances of the City of Inver Grove Heights. I hereby certify or declare under penalty of perjury under the laws of the State of Minnesota that I have read and understand every question in this application and that the answer to every question and in all supplemental documents submitted on behalf of this application are true and correct to the best of my knowledge, information and belief. I further understand that the giving of false information in this application, regardless of when it is discovered, and or the failure to give required pertinent information constitutes cause for the immediate revocation of any and all licenses and/or permits issued hereunder and may be grounds for prosecution for perjury. All information given is subject to verification by the State of Minnesota.**

**A SIGNATURE IS REQUIRED IN ORDER TO PROCESS THIS APPLICATION**

Signature_____ Date_____

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____day of _____, 20____

_____ My Commission expires on:_____
Signature of Notary Public

(Stamp)

| FOR CITY USE ONLY | | |
|---|---|---|
| Tentative Due Date: | Date received and license fee paid: | Deposit Required: |
| | | _____Yes Amount collected: ____-_____<br>_____No |
| Financials: ☐ | Other: ☐ | Other: ☐ |

| FOR POLICE DEPARTMENT USE ONLY | | | |
|---|---|---|---|
| Case File #: | Records: | Date assigned: | Date completed: |
| | | | |

| BACKGROUND CHECKS | | |
|---|---|---|
| RMS ☐ | CCH ☐ | Other: ☐ |
| Other: ☐ | Other: ☐ | Other: ☐ |

| BACKGROUND SUMMARY | |
|---|---|
| Approval Recommended | |
| The renewal background is complete and ***there is nothing*** in the background of the applicant ***which should not exclude*** them from obtaining a license (see attach documents for further information). | ☐ |
| Denial Recommended | |
| The renewal background is complete and ***there is information*** in the background of the applicant ***which excludes*** them from obtaining a license (see attached documents for further information). | ☐ |

**FINAL REVIEW**

I respectfully submit the renewal background findings to the City Council for use in determining whether the applicant should be granted a renewed license.

Signature: _____ Date: _____, 20__
Chief of Police