

## Massage License Application

Government data practices act-Tennessee warning: The data you supply on this form will be used to process the license you are applying for. You are not legally required to provide this data, but we will not be able to process the license without it. The data will constitute a public record if and when the license is granted.

Name of Business: _____				
Business Address: _____				
	Street	City	State	Zip
<b>Business Owner Information:</b>				
Owner's Name: _____				
	First	Middle		Last
Address (PO Box not allowed): _____				
	Street	City	State	Zip
Mailing address: _____				
	Street	City	State	Zip
Phone 1 #: _____ Phone 2 #: _____				
Email Address: _____				
MN Tax ID # or Social Security #: _____				
<b>For corporations or partnerships, please list each officer shareholder or partner. Attach additional sheets if necessary:</b>				
1. Name: _____				
	First	Middle		Last
Address: _____				
	Street	City	State	Zip
	Date of birth (mm/dd/yyyy)	Place of birth	Business phone	
2. Name: _____				
	First	Middle		Last
Address: _____				
	Street	City	State	Zip
	Date of birth (mm/dd/yyyy)	Place of birth	Business phone	
<b>Please complete reverse side</b>				
<b>Office use only</b>				
Date: _____ Receipt: _____ Amount Received: _____				
Received by: _____ Method: <input type="checkbox"/> Check <input type="checkbox"/> Credit/Debit Card <input type="checkbox"/> Cash				
Date License approved by Council: _____ TRAKit Code: _____				

**Person supervising massage:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Previous crimes or offenses** Please describe any crime or other offenses, including the time, place, date and disposition for which any of the persons named on the previous page or above have been arrested or convicted:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please list each massage therapist performing services for this business:** (Attach additional sheets if necessary)

1.Name: \_\_\_\_\_

First Middle Last

Address: \_\_\_\_\_

Street City State Zip

Date of birth (mm/dd/yyyy) Place of birth Business phone

2.Name: \_\_\_\_\_

First Middle Last

Address: \_\_\_\_\_

Street City State Zip

Date of birth (mm/dd/yyyy) Place of birth Business phone

3.Name: \_\_\_\_\_

First Middle Last

Address: \_\_\_\_\_

Street City State Zip

Date of birth (mm/dd/yyyy) Place of birth Business phone

**Description of premises to be licensed**

Has there been or will there be any new construction or alteration of existing structures for this facility? Yes No

*Please contact the Building and Safety Department at 320-255-7239 for information regarding building, plumbing, electrical, and ventilation permit requirements.*

Is this business located within your home? Yes No

What type of services will be offered?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What parking facilities are available for this location?

\_\_\_\_\_

**Massage Facility Application page 3 of 3**

**Description of premises to be licensed (continued)**

Are there laundry facilities on the premises?    Yes    No

If no, where will items be laundered? \_\_\_\_\_

Number of massage tables at this business \_\_\_\_\_    Number of massage chairs \_\_\_\_\_

Number of employees (massage only) \_\_\_\_\_

**Enclose the following items.**

1. Provide a state issued id or photocopy for owner, manager, massage supervisor and each massage therapist.
2. A license fee of \$76.00 plus the Review and Investigation fee for new facilities (\$200 for a single owner; \$400 for a partnership or corporation) make check payable to the City of St. Cloud. Credit card payments are also accepted at City Hall or by phone 320-255-7214.
3. Provide Consent to Release Private Data form for each owner, manager, massage supervisor, and massage therapist
4. A signed Certificate of Compliance of Minnesota Workers Compensation Law
5. Proof of membership in either the American Massage Therapy Association or Associated Bodyworks & Massage Professionals for all massage therapists **or** for the person(s) who is providing supervisory direction. *All services shall be provided by, or be under the direction of an insured member in good standing of accepted massage associations.*
6. A drawing to scale of the massage facility to be licensed.

**Incomplete applications will be returned.**

**I understand that it is my responsibility to submit all required fees and obtain all necessary approvals prior to operating.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed name \_\_\_\_\_

Relationship to Facility:    Owner    Manager    Other \_\_\_\_\_



# Certificate of Compliance Minnesota Workers' Compensation Law

**THIS FORM MUST BE COMPLETED BY THE BUSINESS LICENSE APPLICANT**

**PRINT IN INK or TYPE**

Minnesota Statutes §176.182 requires every state and local licensing agency to withhold the issuance or renewal of a license or permit to operate a business in Minnesota until the applicant presents acceptable evidence of compliance with the workers' compensation insurance coverage requirement of Minnesota Statutes Chapter 176. If the required information is not provided or is falsely stated it shall result in a \$2,000 penalty assessed against the applicant by the commissioner of the Department of Labor and Industry.

A valid workers' compensation policy must be kept in effect at all times by employers as required by law.

License or certificate number (if applicable)	Business telephone number	Alternate telephone number	
Business name (Provide the legal name of the business entity. If the business is a sole proprietor or partnership, provide the owner's name(s), for example John Doe, or John Doe and Jane Doe.)			
DBA ("doing business as" or "also known as" an assumed name), if applicable			
Business address (must be physical street address, no P.O. boxes)	City	State	ZIP code
County	Email address		

**YOUR LICENSE OR CERTIFICATE WILL NOT BE ISSUED WITHOUT THE FOLLOWING INFORMATION. *You must complete number 1 or 2 below.***

### Number 1 – Workers' compensation insurance policy information

Insurance company name (not the insurance agent)	NAIC number	
Policy number	Effective date	Expiration date

### Number 2 – Reason for exemption from workers' compensation insurance

If you have questions regarding the need to obtain workers' compensation coverage, including exemptions, call (651) 284-5032 or 1-800-342-5354.

- I have no employees. (See [Minnesota Statute § 176.011, subd. 9](#) for the definition of an employee.)
- I am self-insured for workers' compensation (attach a copy of the authorization to self-insure from the [Minnesota Department of Commerce](#)).
- I have employees but they are not covered by the workers' compensation law. (See [Minnesota Statute § 176.041](#) for a list of excluded employees.) Explain why your employees are not covered:  
  
\_\_\_\_\_

I certify the information provided on this form is accurate and complete. If I am signing on behalf of a business, I certify I am authorized to sign on behalf of the business.

**Print name**

Applicant signature (required)	Title	Date
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NOTE: You must notify the authority issuing your license if there is any change to your workers' compensation insurance information or an employee status change by resubmitting this form. This material can be made available in different forms, such as large print, Braille or audio.