HEALTH & INSPECTIONS DEPARTMENT
Environmental Health
1201 7th Street South
St. Cloud MN 56301
Phone (320) 255-7214 Fax (320) 650-3145
www.ci.stcloud.mn.us

Massage Establishment License:

Please insure you have all the required items before submitting application

REQUIREMENTS CHECKLIST:

_____ Completed Application

_____ Initial plan review and investigation fee (see below for fees)

Number of massage therapists:	Fee:
1-3	$300.00
4-10	$400.00
More than 10	$500.00

_____ PERSON HISTORY FORM and CONSENT TO RELEASE PRIVATE DATA FORM for all applicants, owners, managers, and others having a financial interest in this establishment

_____ Workers Compensation Coverage Form

_____ Evidence of Legal Work Status in United States

_____ Current Valid State or United States Government issued ID

_____ Proof of Insurance

_____ Copies of partnership agreement or certificate of incorporation

_____ Photocopy of driver license or identification card for all applicants, owners, managers, and others having a financial interest in this establishment

CITY OF ST.CLOUD MINNESOTA

Massage Establishment License Application

Health & Inspections Department
Environmental Health
1201 7th Street South / St/ Cloud MN 56301
Phone: (320) 255-7214 / Fax: (320) 650-3145 / www.ci.stcloud.mn.us

Government data practices act-Tennesson 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 date, 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 greater.

Processing the application can take (amount) days or longer. You may not operate the massage enterprise business until the license has been issued. Violating city ordinance is grounds for denial.

Part I – General

Establishment Name: _____

Establishment Address: _____
Street City State Zip Code

Business Contact: _____ Title: _____

Phone _____ Email: _____

On-Site Manager or Agent's Name: _____ Phone: _____

Home Address: _____
Street City State Zip Code

Tax ID or Social Security Number: _____

Provide the legal description of the premise to be licensed. If the premise is being remodeled, under construction, or undergoing substantial alterations, the application shall be accompanied by a set of preliminary plans showing the design of the proposed premises to be licensed. If the plans for design are already on file with the City's Building Inspections Division, no plans need to be submitted.

_____

_____

_____

Office use only

Date: _____ **Receipt:** _____ **Amount Received:** _____

Received by: _____ **Method:** ☐**Check** ☐**Credit/Debit Card** ☐**Cash**

Date License approved by Council: _____ **TRAKiT Code:** _____

Section 1: Applicant

A "PERSONAL HISTORY FORM" AND "CONSENT TO RELEASE PRIVATE DATA FORM" MUST BE COMPLETED FOR THE APPLICANT

Applicant's Relationship to Business: _____

Individual *If applicable, complete this question and a* Part II Personal History *form.*

Name _____ Maiden name _____
Last First Full middle

Residence address _____
Street City County State Zip

Residence phone (_____) _____ Business phone (_____) _____

Business address _____
Street City County State Zip

Section 2: Other Business Information

Type of Business: □ Sole Proprietorship □ Partnership □ Cooperation □ LLC □ Other _____

List all owners, businesses, partnerships, cooperation and LLC owners and all other individuals having a financial interest in this establishment. Do not list massage therapists in this section unless they have a financial interest in the establishment, other than their employment. Attach additional pages as needed.

A "PERSONAL HISTORY FORM" AND "CONSENT TO RELEASE PRIVATE DATA FORM" MUST BE COMPLETED FOR ALL LISTED IN THIS SECTION

Full name _____
Last First Full middle Maiden name

Residence _____ Phone (_____) _____
Street City State Zip

Business _____ Phone (_____) _____
Street City State Zip

Email _____

Relationship to business _____

Full name _____
Last First Full middle Maiden name

Residence _____ Phone (_____) _____
Street City State Zip

Business _____ Phone (_____) _____
Street City State Zip

Email _____

Relationship to business _____

Full name ____
Last First Full middle Maiden name

Residence ____Phone (______) ______________
Street City State Zip

Business ____Phone (______) ______________
Street City State Zip

Email ____

Relationship to business____

Full name ____
Last First Full middle Maiden name

Residence ____Phone (______) ______________
Street City State Zip

Business ____Phone (______) ______________
Street City State Zip

Email ____

Relationship to business____

Full name ____
Last First Full middle Maiden name

Residence ____Phone (______) ______________
Street City State Zip

Business ____Phone (______) ______________
Street City State Zip

Email ____

Relationship to business____

Full name ____
Last First Full middle Maiden name

Residence ____Phone (______) ______________
Street City State Zip

Business ____Phone (______) ______________
Street City State Zip

Email ____

Relationship to business____

Attach
1. A copy of the Certificate of Incorporation.
2. Foreign corporations attach a copy of Certificate of Authority, as required by *Minnesota Statutes, Section 303.06*.
3. Certificate of Assumed Name.

Section 2: On-site manager or agent

A "PERSONAL HISTORY FORM" AND "CONSENT TO RELEASE PRIVATE DATA FORM" MUST BE COMPLETED FOR ALL LISTED

Designated on-site manager or agent of the applicant in charge of the licensed premises.

Name _____ Position _____

Last First Full middle Maiden name

Residence _____ Phone (_____) _____

Street City State Zip

Section 3: Massage Therapists

Provide a list of all massage therapists that will be working at your enterprise and proof they are all licensed by the City of St. Cloud. Please include: full name, date of birth and license number for each therapist.
Attach additional pages as needed.

_____

_____

_____

_____

_____

_____

_____

_____

The data on this form will be used to approve your license. Some requested data is private. Private data is available to you and the City or State staff who need this information to perform their duties, but is not available to the public. You are not legally required to provide this data, but the City may not be able to approve your license if you do not provide it.

I understand that a criminal conviction will not bar me from obtaining a license unless the conviction is directly related to the occupation for which the license is sought and there is no showing of sufficient rehabilitation and present fitness to perform the duties of the occupation (Minnesota Statute 364.03). I understand that falsification of the application, including failure to reveal a criminal conviction, constitutes grounds for denial of the license.

The information I have provided on this application is truthful. I authorize the City of ST. Cloud to verify any and all of the information requested on this application, including the ordering of criminal background checks, and to conduct any necessary investigation to assure this application complies with the licensing and zoning ordinances.

Applicant Signature: _____ **Date:** _____

Printed Name : _____

CITY OF ST.CLOUD MINNESOTA

Massage Establishment
PERSONAL HISTORY FORM

Government data practices act-Tennesson 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 date, 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 greater.

Personal History

To be filled out by the sole owner, each general and managing partner, each officer or director, each general manager, proprietor, manager or any other individual or agent in charge of the licensed premises and by each person who by combined ownership or control has an interest in excess of 5 percent. *Please use additional paper if needed.*

Establishment Name: _____

Establishment Address: _____
Street City State Zip Code

Full name _____
Last First Full middle Maiden name

Position _____

Residence _____ Phone (_____) _____
Street City State Zip

Height _____ Weight _____ Color of hair _____ Color of eyes _____

Place of birth _____Date of birth _____

Proof of Identification: _____ Driver's License _____Military ID _____ Passport _____Other

Have you ever used/been known by a name other than your true name? _____Yes _____No
If yes, list the name(s) and any information concerning the date(s) and place(s) where used.

_____

_____

Are you a U.S Citizen? *If yes, but birthplace was not in the U.S., please provide a Certificate of Naturalization, Certificate of citizenship or current passport. If no, present proof of immigration/employment status.* _____Yes _____No

Do you have legal work status in the United States? _____Yes _____No

List the addresses and dates at which you have lived during the preceding 10 years. Attach additional pages as needed.

Address	Dates
Address	Dates
Address	Dates
Address	Dates
Address	Dates

List the type, name, location and dates of every business or occupation you have engaged in during the preceding ten (10) years. Attach additional pages as needed.

Type	Name	Location	Dates
Type	Name	Location	Dates
Type	Name	Location	Dates
Type	Name	Location	Dates
Type	Name	Location	Dates

Have you ever had a massage therapist or massage establishment license in the City of St. Cloud?
_____Yes _____ No If yes, please list and

Name	License #	Date

Have you ever had a massage therapist or massage establishment license in any other city or state?
_____Yes _____ No
If yes, please provide details.

Name	City/State	License #	Phone#
Name	City/State	License #	Phone#

Are you currently licensed to perform massage therapy in other communities? _____Yes _____No
If yes, list the name(s) and any information concerning the date(s) and place(s) where used.

_____

List the establishments in which you have engaged in the operation of massage services.

Name	Location	Dates
Name	Location	Dates
Name	Location	Dates
Name	Location	Dates
Name	Location	Dates

Have you ever had a massage therapist or massage enterprise license denied, suspended or revoked within the preceding ten (10) years? _____Yes _____No
If yes, please provide details and additional sheets if needed:

License number	City	State	Duration
License number	City	State	Duration
License number	City	State	Duration

Have you ever been arrested, charged or convicted of any crime, or violation of any ordinance other than a minor traffic offense? _____ Yes _____ No
If yes, please provide details additional sheets if needed:

Date(s)	Time	Location	Offense
Date(s)	Time	Location	Offense
Date(s)	Time	Location	Offense

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The information I have provided on this application is truthful. I authorize the City of ST. Cloud to verify any and all of the information requested on this application, including the ordering of criminal background checks, and to conduct any necessary investigation to assure this application complies with the licensing and zoning ordinances.

Signature: _____ **Date:**_____

Printed Name : _____

CITY OF ST. CLOUD MINNESOTA
Health & Inspections Department

CONSENT TO RELEASE PRIVATE DATA FORM

Massage License Applicants and Renewal Applicants
Every Owner, Manager, and Massage Supervisor must complete this form.

In accordance with the Minnesota Government Data Practices Act, the City of St. Cloud is required to inform you of your rights as they relate to the private information collected from you. Private data is information, which is available to you, but not to the public; the personal information we collect about you is private governed by Minnesota Statute 13.04, subdivision 2.

The purpose and intended use of this information is to perform background investigations of the applicant, manager and/or others appearing on the application. This information will be used to determine if it is appropriate for the applicant to be issued a license or permit from the City of St Cloud. This information will be used by various City departments in the course of their investigations. In addition, various State and Federal law enforcement agencies may be furnished portions of the information you provide.

You are not legally required to provide this information. However, failure to furnish the requested information may result in your application being denied. If you have any questions in this regard, please contact the Health and Inspections Department at (320) 255-7214.

PLEASE PRINT

I am (check all that apply) ☐ Owner ☐ Manager ☐ Massage supervisor ☐ Other _____

For the following massage facility: _____

I, _____
First name *Full middle name* *Last name*

authorize the City of St. Cloud to release the following private data about me to all agencies, departments and individuals involved in the investigation for issuance of a massage facility license. The person(s) receiving the private data may use it only for the purpose of evaluating my application for, or renewal of, a massage facility license.

1. Any other name(s) or nicknames you have been known by: _____
2. Date of birth (mm/dd/yyyy): _____
3. Home address: _____
Street *City* *State* *Zip*
4. Phone number: _____
5. Race: _____ 6. Sex: _____
6. **ENCLOSE A PHOTOCOPY OF A STATE ISSUED ID**

To the following person(s): All agencies, departments and individuals involved in the investigation for and/or issuance of a massage license. The person(s) receiving the private data may use it only for the purpose of evaluating my application for or renewal of a massage license.
I agree to give up and waive all claims that I might have against the City, its agents and employees for releasing data pursuant to this request. **This authorization expires one year from date submitted.**

_____ _____
Signature Date