BOROUGH OF CARLSTADT
Office of the Borough Clerk
Memorial Municipal Building
500 Madison Street
Carlstadt, NJ 07072

MASSAGE THERAPY TECHNICIAN/PRACTITIONER LICENSE

DATE APPLICATION FILED: _____ FEE: $100.00

THIS APPLICATION IS FOR: _____ A New Massage Technician/Practitioner License

_____Renewal of Massage Technician/Practitioner License

_____ Amendment of Application on File

1. Applicant's name _____

   Street Address _____
   Number Street Name

   Municipality _____State _____ Zip _____- ____

   Telephone (_____) _____ - _____

2. Applicant's date and place of birth.

   Date of Birth _____

   Place of Birth _____ and _____
   City State

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

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

4. Have you ever been arrested or convicted of a crime? Yes____ No _____
   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)
   _____

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.

14. 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: _____