



City of Apple Valley
 7100 147th Street W.
 Apple Valley, MN 55124
 (952) 953-2500

MASSAGE THERAPIST LICENSE APPLICATION

To be completed by the massage therapist.

Section 1: Business

1. Complete the following for the massage therapy business you are employed by, affiliated with, or own:

Business name _____ Phone _____

Business address _____ Apple Valley MN 55124
Street City State Zip

2. What percentage (%) of financial interest do you have in this massage therapy business? _____ %

Section 2: Applicant

3. Complete the following information:

Legal name _____
First Middle Last Maiden Name

Home address _____
Street City County State Zip

Phone _____ Email address _____

Date of birth _____ Place of birth _____
mm/dd/yyyy City/State/Country

Social Security Number (required per MN Stat. § 270C.72) _____

Minnesota Business Tax ID Number (required per MN Stat. § 270C.72) _____
(7-digit number)

4. Have you ever used or been known by a name(s) other than the legal name given above? No Yes
If yes, list such name(s) and information concerning dates and places used.

5. Are you a U.S. citizen or legally permitted to be in the U.S.? No Yes
*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.*

6. Are you a resident of the State of Minnesota or a resident of one of the following Wisconsin counties: Pierce, St. Croix, Pepin, Dunn, Polk? No Yes

7. Address(es) at which you have resided during the preceding ten (10) years, include seasonal or part-time locations.

Street City State Dates

Street City State Dates

Street City State Dates

Street City State Dates

8. Employers for the preceding ten (10) years. *Include name, address, and dates of employment.*

Employer	Street	City	State	Dates

9. Have you ever been criminally convicted of any federal, state, county, or local law or regulation other than a minor traffic violation? *If yes, provide the date, place, and nature of offense.* No Yes

10. Have you ever been engaged in the operation of massage services? *If yes, provide name, place, and length of time of involvement in such establishment.* No Yes

11. Have you individually, or with others, made an application for a massage therapy license which was denied? *If yes, provide place and explanation.* No Yes

12. Have you had a massage therapy license suspended or revoked within the last 10 years? *If yes, provide date, place, and explanation.* No Yes

Section 3: Identification and Documentation Required

13. You are required to produce an original or legible photocopy of identification at the time of filing this application. Check one (1) of the following:

- Valid Driver's License or Identification Card
- Valid Passport
- Valid Military ID Card

14. You are required to provide proof of training and/or experience. Check one (1) of the following:

- Completion of a minimum 500 credit hours of certified therapeutic massage training/course work.
- Diploma or certificate of graduation from an accredited institution/program in massage therapy.
- Proof of passing the National Certification Exam offered by the National Certification Board for Therapeutic Massage & Bodywork and a minimum of seven (7) years full-time work experience as a massage therapist in the United States.

Section 3: Identification and Documentation Required

15. ATTACH:

- Proof of general liability insurance coverage with a minimum of \$300,000 combined single limit per occurrence.
- Completed Massage Therapy License Verification Release Form, which provides authorization to conduct a background investigation and to verify education/training credentials and work experience.

Section 4: Notice and Notarized Signature

Applicant may subscribe to receive an electronic notification from the City of proposed ordinances by signing up for *Email Updates* on the City's website at www.cityofapplevalley.org.

I hereby certify that the information supplied on this application form and all attachments is true and correct. The information requested on this form will be used by the City of Apple Valley to approve or deny the applicant's license. I understand that the falsification or misrepresentation of information submitted on or with my application constitutes grounds for denial of the license. I authorize the City of Apple Valley 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 City's licensing and zoning ordinances.

The information supplied on this form will become public information when received by the City of Apple Valley. Under Minnesota law (Minn. Stat. § 270.72), the City may be required to provide the business tax identification number and/or social security number of each applicant to the Minnesota Commissioner of Revenue.

I also acknowledge that I have received and/or reviewed Chapter 123 of the City Code, regarding Massage Therapy Business and Massage Therapist Licenses, and am familiar with the provisions thereof.

Subscribed and sworn to before me this

X _____
Applicant Signature

_____ day of _____, 2018.

Printed Name

Notary Public

Fees:

New Application Fee \$110.00
Renewal Application Fee \$ 82.00

All licenses expire June 30th.

01/18	For office use only	Code to: 1001-4038
Appl. Rec'd _____	Date Fee Paid _____	Amount _____
Appl. to Police _____	Approve/Deny _____	Receipt No. _____
		License No. _____