MASSAGE ESTABLISHMENT LICENSE FORMS AND CHECKLIST

- Application
- Operator's Permit Application
- Business Plan
- Practitioners List
- Lease/Rental agreement or deed for proof of property ownership

ENVIRONMENTAL HEALTH PERMIT APPLICATION FORM
TO OPERATE A MASSAGE ESTABLISHMENT

Environmental Health Division of Public Health Services Department **661-862-8740**
2700 "M" Street, Suite 300, Bakersfield, CA 93301 **661-862-8701(fax)**

Date of Application:	**SERVICE REQUEST NUMBER:**
BUSINESS NAME:	**TYPE OF OWNERSHIP:**
ADDRESS:	☐ Sole Proprietor ☐ Ownership Change ☐ New Business ☐ Corporation ☐ Partnership ☐ Information Change
CROSS STREET:	**BUSINESS PHONE NO.** / **CELL PHONE NO.**

NAME OF BUSINESS OWNER: a) Person to whom permit will be issued, or b) Corporation name and names of principal Officers and stockholders with more than or equal to 10% ownership Mailing Address: _____ Care Of: _____ E-mail Address: _____	**HOME ADDRESS** OF: a) each applicant with birth date, or b) each practitioner for Solo Practitioner Establishment, or c) Corporation and Corporate Officers **CONTACT PERSON:**
EMERGENCY NAME & PHONE:	**HOME TELEPHONE:**

HAS ANY APPLICANT, including corporate officers and stockholders, **EVER BEEN CONVICTED OF ANY FELONY OR MISDEMEANOR** ☐ No ☐ Yes *If yes*, please attach a list of each conviction along with the date of the revocation conviction.

Are you currently pending any investigation regarding any felonies, establishment misdemeanors or lewd conduct
☐ No ☐ Yes
If yes, please attach a list of each conviction along with the date of the revocation conviction.

Have you ever had any massage license denied, suspended, or revoked:
☐ No ☐ Yes
If yes, please attach information about the license denial, or suspension, including dates.

ATTACH:
1) OPERATOR'S PERMIT APPLICATION FOR MASSAGE ESTABLISHMENT
2) BUSINESS PLAN WHICH DESCRIBES THE EXACT NATURE OF THE SERVICES TO BE PROVIDED
3) PRACTITIONER LIST (FOR MASSAGE ESTABLISHMENTS) WITH DATE OF BIRTH
4) LIST OF PREVIOUS MASSAGE PERMITS OR LICENSES HELD WITH STATUS DESCRIBED

I declare under penalty of perjury the information on this application and in other materials submitted in support of this application are true and correct. I hereby consent to all necessary inspections made pursuant to the Massage Ordinance and incidental to the issuance of any exemption, Registration or Permit, and operation of this business. I have checked with the Planning Department prior to submitting this application to verify that this location is zoned for a Massage Establishment. **I understand that once submitted the application fee is nonrefundable.**

***SIGNATURE(S) OF APPLICANT(S)**

_____ _____

_____ _____

***If Partnership, all partners must sign. If Corporation, authorized Officer must sign. Attach extra sheets if necessary.**

FOR OFFICE USE ONLY

☐	Permit Fee	☐	Zoning Referral	☐	Lease Agreement	☐	Previous Permits
☐	Receipt #	☐	BID Referral	☐	Practitioner List	☐	Home Addresses
☐	Out of Business Notification	☐	Fire Dept. Referral	☐	Owner(s) Background Check	☐	Corporate Address

Program ID:	PE:	Date Mailed:	Facility ID:
Total Fees Paid:	Received By:	Date Paid:	Accounting ID:
New Owner ID:			

Zoning Approved By: _____ Date: _____

New permit inspection conducted by: _____ Date: _____
If denied: Denial letter sent: ☐ Yes ☐ No Date: _____

APPROVED: ☐ ***YES*** ☐ ***NO***
DATE: _____

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Operator's Permit Application for Massage Establishment

MASSAGE BUSINESS OWNER AND OPERATOR

The following section requires a complete description of the owner and operator(s) who will be principally in charge of the operation of the massage establishment. *On a separate sheet, provide all the residential addresses and telephone numbers; date and place of birth; CA driver's license, CA ID card, or resident alien card (if applicable); CAMTC card; acceptable written proof that the owner and operator is at least eighteen years of age; height, weight, gender, color of hair, and eyes of* ***each*** *owner* ***and*** *operator; for a minimum of eight (8) years preceding the present address and dates of residences for each address.*

True Name & Aliases	Height, Weight, Hair Color, Eye Color, and Gender
Home Address	City, State, Zip Code
Home Phone	Cell Phone
E-Mail	Date & Place of Birth
Driver's License Number	CAMTC Number (if applicable)

On the lines below, describe any other business operated on the same premises as the proposed massage establishment, or within the City or the State, which is owned or operated by the owner or operator.

_____

_____

PROPERTY OWNER/LESSOR

The following section requires information about the Owner and Lessor of the property upon which the proposed business is to be conducted. In the event, the applicant is not the legal owner of the property, attach a copy of the lease agreement and notarized affidavit from the property owner acknowledging that a massage establishment will be located on his/her property.

Name:	
Home Address	City, State, Zip Code

PREVIOUS BUSINESS/OCCUPATION/EMPLOYMENT

This section requires a complete business, occupation, and employment history for eight (8) years preceding the date of this application, including, but not limited to, any massage establishments or similar type of business history and experience. *Attach additional sheets if necessary.*

Company:		
Address:	Phone	( )

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BUSINESS PLAN FOR: _____

☐ EXISTING ☐ NEW DATE: _____

DBA: _____ Business Phone: _____

Address: _____ On Site Manager: _____
(MANAGER DURING NORMAL WORKING HOURS)

TYPE OF ESTABLISHMENT:	EMPLOYEES:	OPERATIONS:	# OF ROOMS:
☐ GENERAL ☐ SOLO	TOTAL: _____ M _____ F _____	DAYS: _____ HOURS: _____	THERAPY: _____ TOILET: _____

Describe the type of massage therapy used by your practitioners (i. e. Shiatsu, Swedish, Deep Tissue, etc.)

ATTACH A FLOOR PLAN OF YOUR ESTABLISHMENT SHOWING: SHOWERS, TOILETS, THERAPY & CHANGE ROOMS, HANDWASH & MOP SINKS, AND CLEAN & DIRTY LINEN STORAGE.

I declare under penalty of perjury that the information on this business plan, to the best of my knowledge, is true and correct. I hereby consent to all necessary inspections made pursuant to the Massage Ordinance and incidental to the issuance of any exemption, registration or permit, and operation of this business.

NAME (PRINTED)	SIGNATURE	DATE

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PRACTITIONERS' LIST FOR: _____

☐ EXISTING ☐ NEW DATE: _____

DBA: _____ Business Phone: _____

Address: _____ On Site Manager: _____
(MANAGER DURING NORMAL BUSINESS HOURS)

	FIRST & LAST NAME OF MASSAGE PRACTITIONER, HOME ADDRESS, TELEPHONE NUMBER AND DATE OF BIRTH	CAMTC PERMIT#	Office Use ONLY Active?
1			☐ YES ☐ NO CERTIFICATE
2			☐ YES ☐ NO CERTIFICATE
3			☐ YES ☐ NO CERTIFICATE
4			☐ YES ☐ NO CERTIFICATE
5			☐ YES ☐ NO CERTIFICATE
6			☐ YES ☐ NO CERTIFICATE
7			☐ YES ☐ NO CERTIFICATE
8			☐ YES ☐ NO CERTIFICATE
9			☐ YES ☐ NO CERTIFICATE
10			☐ YES ☐ NO CERTIFICATE
11			☐ YES ☐ NO CERTIFICATE
12			☐ YES ☐ NO CERTIFICATE

PLEASE ATTACH ANOTHER PAGE IF THERE ARE MORE THAN TWELVE (12) PRACTITIONERS AT THIS FACILITY.