**Fee Paid _____**

**Date of Registration_____**

# WEST HARTFORD-BLOOMFIELD HEALTH DISTRICT
## 580 Cottage Grove Road, Suite 100, Bloomfield, CT 06002
## (860) 561-7900, FAX (860) 561-7918

## Massage Therapy Establishment Permit Application

Name of Establishment_____

Address of Establishment_____
Street Town State Zip Code

Business Phone # _____ FAX #_____E-Mail _____

Days/Hours of Operation_____

Mailing Address_____
Street Town State Zip Code

**Billing Address**_____
Street Town State Zip Code

Applicant's Name _____

Home Address_____
Street Town State Zip Code

Applicant's Phone # _____ Applicant's DOB: _____

Manager's Name_____

Manager's Home Address_____
Street Town State Zip Code

Manager's Home/Emergency Phone # _____Manager's E-Mail _____

**PROVIDE NAME AND PHONE NUMBER OF THE PERSON(S) TO CONTACT IN CASE OF EMERGENCY:**

_____

**Please enclose:**
**A non-refundable fee of seventy-five dollars ($75).**
**A photocopy of the applicant's current CT Driver's License or other valid photo ID. Photocopies of employees' State of Connecticut Massage Therapist licenses**

**I agree to operate this massage therapy establishment in accordance with the Massage Therapy Establishment Ordinance. I understand that, as the applicant, I am responsible for the massage therapy establishment. I understand that any questions not answered or any false or misleading answers contained herein shall be grounds for immediate rejection of this application or closure of the massage therapy establishment registered hereunder.**

_____ _____

Applicant (**Please Print**) Applicant's Signature

*Revised 8/9/2016*