

# RI Department of Health

## Application and Instructions for:



### Massage Therapy Establishment

\_\_\_\_\_  
Applicant Name (Name of Business)

\_\_\_\_\_  
Previous Business Name & License Number (If Any) at this address

#### OFFICE USE ONLY

	Initials	Date
Risk Type		
Approved by F.O. Supervisor		
Profile Entered By		
License ID#		
Receipt No.		
License No.		

# INSTRUCTIONS

- Registration shall be based upon **Satisfactory Compliance** with all applicable laws and regulations.
- Registration forms must be either typed or legibly printed using a ball point pen, except signatures, which must be written in ink. Please answer all questions. Do not leave blanks. Incomplete applications will be returned to you and your license/permit will not be issued.
- Attach check/money order to the front of this application and mail to: Office of Food Protection, 3 Capitol Hill, Room 203, Providence, RI 02908-5097. A receipt or cancelled check does not guarantee licensure.

## Application Fees:

**Massage Therapy Establishment**

**\$170.00**

- Make your check/money order payable to "General Treasurer, State of Rhode Island". Do not send cash. This fee is non-refundable.
- If you have any questions concerning this application, call the Department of Health, Office of Food Protection at (401) 222-2749.
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

**Please complete section(s) below.**

**NOTE: A licensed Massage Therapist is required to operate a Massage Therapy Establishment.**

<p><b>Licensed Massage Therapist:</b></p> <p>Please indicate the license number of the designated Massage Therapist(s) who provides service at this location. (Owner/manager or designee).</p>	<p>Name: _____</p> <p>License Number: _____</p>
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**State of Rhode Island and Providence Plantations**  
**Department of Health**  
**Office of Food Protection**

**Facility Name:**

Please provide the name of the facility (as known to the public) for which you are applying for this license.

Name: \_\_\_\_\_

**Facility Contact Person:**

Please provide the name and telephone number of a person we can contact concerning this facility.

Name: \_\_\_\_\_

Phone Number:  
 (        ) \_\_\_\_\_

**Facility Mailing Information:**

Please provide the mailing information for all communication regarding this license.

**(Not published on HEALTH website).**

Address Line 1 \_\_\_\_\_

Address Line 2 \_\_\_\_\_

Address Line 3 \_\_\_\_\_

City, State, ZipCode \_\_\_\_\_

Country (only if not in US) \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Facility Location Information:**

Please provide the location information for this facility.

**(Published on HEALTH website)**

Address Line 1 \_\_\_\_\_

Address Line 2 \_\_\_\_\_

Address Line 3 \_\_\_\_\_

City, State, ZipCode \_\_\_\_\_

Country (only if not in US) \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Ownership Type:**

Please check ONE

- |  |  |
|--|--|
| <input type="checkbox"/> Corporation         | <input type="checkbox"/> Limited Liability Company |
| <input type="checkbox"/> Governmental Entity | <input type="checkbox"/> Sole Proprietorship       |
| <input type="checkbox"/> Partnership         | <input type="checkbox"/> Limited Partnership       |
| <input type="checkbox"/> Partner             |  |

**Ownership Information:**

Please provide the ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.

**LIST ALL OWNERS (MUST BE 18 YEARS OR OLDER; COPY OF BIRTH CERTIFICATE OR DRIVER'S LICENSE) ATTACH A SEPARATE PAGE IF NEEDED.**

Name: \_\_\_\_\_

DBA (Doing Business As): \_\_\_\_\_

<p><b>Ownership Address Information:</b></p> <p>Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Governmental Entity.</p>	<p>Address Line 1 _____</p> <p>Address Line 2 _____</p> <p>Address Line 3 _____</p> <p>City, State, Zipcode _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Email Address: _____</p>
<p><b>Water Supply:</b></p>	<p>Does this establishment receive all or a portion of its water supply from an on-site well?</p> <p><input type="checkbox"/> Yes                      <input type="checkbox"/> No</p>
<p><b>Sewage System:</b></p>	<p>Is this establishment serviced by a private sewage system (e.g. septic system)?</p> <p><input type="checkbox"/> Yes                      <input type="checkbox"/> No</p>
<p><b>Criminal Conviction</b></p>	<p>Attach any criminal convictions of corporation and all owners and /or managers or agents. Attach Nationwide Criminal Records check from state or local police; fingerprinting required (Title 23;Chapter 23-20.8(f)).</p>
<p><b>Certificates of Compliance</b></p>	<p>Attach appropriate certificates of compliance with sanitary and sewage codes (if applicable), fire and building codes and zoning laws from local authorities.</p>
<p><b>Operating Policies</b></p>	<p>Attach written operating policies and procedures pertaining to matters such as: hours of operation, nature of services, sanitation and safety procedures established for the protection of patrons and employees, and scale drawing of massage area showing hand washing facilities.</p>
<p><b>Affidavit of Applicant</b></p> <p>Read, sign, and date this affidavit.</p>	<p style="text-align: center;"><b>AFFIDAVIT AND SIGNATURE</b></p> <p style="text-align: center;"><b>This Application Must be Signed</b></p> <p><b>I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.</b></p> <p><b>I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.</b></p> <p>_____</p> <p><b>Signature of Authorized Person</b></p> <p>_____</p> <p><b>Printed Name of Authorized Person</b></p> <p>_____</p> <p><b>Title of Authorized Person</b></p> <p style="text-align: right;">_____</p> <p style="text-align: right;"><b>Date of Signature (MM/DD/YY)</b></p>

**State of Rhode Island and Providence Plantations**



**DEPARTMENT OF HEALTH**

Office of the Director

Cannon Building

3 Capitol Hill

Providence, RI 02908-5097

**Mandatory Addendum to License Application**

Verification of Social Security Number/Federal Employer Identification Number and affidavit concerning taxpayer status

**Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.**

**I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have either paid all taxes due the state or have entered into a written installment agreement with the Rhode Island Division of Taxation.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number (SSN) or Federal Employer Identification Number (FEIN)

**Furnishing the SSN and/or FEIN is mandatory. The SSN and/or FEIN will be transmitted to the Rhode Island Division of Taxation pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended.**

**This form MUST be completed, signed and attached to your license application in order for us to process your application.**