



Administration Department, License  
Division 2660 Civic Center Drive,  
Roseville, MN 55113 (651) 792-7023

## Massage Therapy Establishment License Application Part I

Type of applicant (Select only one)

- Individual, you own the business and have employees
- Sole Proprietorship, you own the business, and you are the only employee
- Partnership       Corporation       Other Organization

Legal Name of Licensee: \_\_\_\_\_

Business Name (dba) \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone \_\_\_\_\_

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

MN Tax ID \_\_\_\_\_ Federal Tax ID \_\_\_\_\_

*Proof of Minnesota Tax Identification form*

Applicant's Social Security Number \_\_\_\_\_

Proof of Worker's Compensation Insurance:

Insurance Company Name \_\_\_\_\_ Dates of Coverage \_\_\_\_\_

Policy Number \_\_\_\_\_

I am **not** required to have worker's compensation liability coverage because

- I have no employees covered by the law
- Other (Specify) \_\_\_\_\_

### Section A: Applicant

**Individual:**

**If applicable, complete this question and Part II Personal History form, then proceed to Section B.**

Name \_\_\_\_\_  
First Last Middle Maiden

Residence Address \_\_\_\_\_  
Street Address City County State Zip

Residence/mobile phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Email address \_\_\_\_\_

**Partnership:**

**If applicable, complete the question for general and limited partners, then proceed to section B.**

**Part II Personal History form is required for each general partner.**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
Street address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Residence/mobile phone \_\_\_\_\_ Business phone \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
Street address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Residence/mobile phone \_\_\_\_\_ Business phone \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
Street address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Residence/mobile phone \_\_\_\_\_ Business phone \_\_\_\_\_

**Corporation/other organization:**

**If applicable, complete the questions, then proceed to Section B. Attach a copy of the Certificate of Incorporation**

**President**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
Street address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Residence/mobile phone \_\_\_\_\_ Business phone \_\_\_\_\_

**Vice President**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
Street address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Residence/mobile phone \_\_\_\_\_ Business phone \_\_\_\_\_

**Secretary**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
Street address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Residence/mobile phone \_\_\_\_\_ Business phone \_\_\_\_\_

**Treasurer**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
Street address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Residence/mobile phone \_\_\_\_\_ Business phone \_\_\_\_\_

**Section B: Persons in charge of licensed establishment**

**General Manager, proprietor, managing partner or any other individual or agent in charge of the establishment.**

**A Part II Personal History must be completed by each person listed in this section.**

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
Street address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Residence/mobile phone \_\_\_\_\_ Business phone \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_  
Street address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Residence/mobile phone \_\_\_\_\_ Business phone \_\_\_\_\_

**Section C: History**  
**Complete separate form for each owner**

Have you, your spouse, parent, brother, sister, or the child of either you or your spouse, ever been engaged as an employee or operated a spa, salon or other business which offered massage?       Yes       No  
If yes, give dates and places.

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Do you and/or your spouse have a direct or indirect interest in any other establishment in the City of Roseville to which a massage therapy establishment license has been issued?       Yes       No  
If yes, list names and addresses of interest.

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Have you, your spouse, parent, brother, sister, or the child of either you or your spouse, ever been convicted of any felony, crime or violation of any ordinance, other than traffic?       Yes       No  
If yes, give date, place and nature of conviction.

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Have you or your spouse had any interest in any previous therapeutic massage license that was revoked, or suspended or not renewed?       Yes       No  
If yes, explain in detail providing dates of such revocation.

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Have you individually, or with others, made an application for a massage license, which was denied?       Yes       No  
If yes, state circumstances.

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What is the amount and source of investments you will have in the business, buildings, premises, fixtures, furniture, stock in trade?

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The information that you are asked to provide on the application is classified by State law as either public, private or confidential. All data, with the exception of driver's license numbers and social security numbers, will constitute public record if and when the license is granted. Our intended use of the information is to perform the background check procedures required prior to license issuance. If you refuse to supply the information, the license application may not be processed.

CONSENT TO BACKGROUND CHECK I hereby consent to and authorize the Roseville Police Department or other qualified service providers in conducting and completing criminal background checks to use the information I have provided to check criminal histories, arrest and driving records, and warrant information; and for the City to consider these records to determine my eligibility for a License. I understand that the information contained in the criminal background investigation is not public, except that it may be conveyed to other law enforcement or licensing agencies.

By signing below you certify that the above information is correct. In addition, you acknowledges that you are responsible for reviewing the background and work history of all of your employees, including those that have received a massage therapist license from the City.

Falsification of answers given or material submitted will result in denial of application.

Applicant signature \_\_\_\_\_ Title \_\_\_\_\_

Date \_\_\_\_\_

Subscribed and sworn to before me, a Notary Public, on this \_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_ . My Commission expires on \_\_\_\_\_.

\_\_\_\_\_  
Notary signature

Notary Stamp

Payment due at the time of application: Annual License Fee \$325

Make checks payable to: City of Roseville

# Massage Therapy Establishment License Application

## Part II Personal History

To be filled out by the sole owner, each general and managing partner, each officer or director, each general manager, proprietor, manager or any other individual or agent in charge of the licensed premises and by each person who by combined ownership or control has an interest in excess of 5%

Establishment where Employed \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City, State ZIP \_\_\_\_\_

### Applicant Name

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Street address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Date of Birth \_\_\_\_\_ Drivers License Number \_\_\_\_\_

Driver's License Number \_\_\_\_\_ State \_\_\_\_\_

Have you ever used or been known by a name or names other than the name given above?  Yes  No

If yes, list such name(s) and information concerning dates and places used:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Address(es) at which you have lived during the preceding five years:

Street	City	State	Zip
Street	City	State	Zip
Street	City	State	Zip
Street	City	State	Zip
Street	City	State	Zip

Name, address and type of every business and occupation you have engaged in during the preceding five years.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name and address of every employer and partner, if any, for the preceding five years:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Marital status  Married  Single  Divorced  Widowed

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By signing below you certify that the above information is correct. Falsification of answers given or material submitted will result in denial of application.

Applicant signature \_\_\_\_\_ Date \_\_\_\_\_