5050 INDEPENDENCE ST | P.O. BOX 97 | MAPLE PLAIN, MN 55359 (763) 479-0515
Ph: (763) 479-0515 | Fax: (763) 479-0519 | www.mapleplain.com

MASSAGE THERAPY ESTABLISHMENT LICENSE APPLICATION

Name (first middle last):		
Other Name Applicant may be known as:		
Name of Business:		
Date of birth:	**SSN:** **MN Tax ID:** **FEIN:**	**Phone:**
Place of birth:		
Current Address:		
City:	**State:**	**ZIP Code:**
Phone:	**Mobile:**	
Driver's License (Provide photo copy of license and license number):		
Previous address (list all in the past five years):		
City:	**State:**	**Zip:**
Dates of Residence:		
City:	**State:**	**Zip:**
Dates of Residence:		
City:	**State:**	**Zip:**
Dates of Residence:		
City:	**State:**	**Zip:**
Dates of Residence:		

ESTABLISHMENT INFORMATION

MASSAGE THERAPY MAY ONLY BE PRACTICED IN AN ESTABLISHMENT LICENSED BY THE CITY OF MAPLE PLAIN.

Name of Establishment:		
Address of New Establishment		
City:	**State:**	**ZIP Code:**
Phone:		

I swear that all information provided above is true to the best of my knowledge, and that I am at least 18 years of age as of the date of this application. I have received a copy of the Municipal Code and understand all of the conditions set forth for holders of a Massage Therapy Establishment License. **I understand that if I violate any part of the code, my license may be revoked. The application is incomplete without proof of insurance and an application fee of $50. Allow at least one month from the date of application submittal for processing of application.**

Signature of applicant	**Date**

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CONSENT FOR THE RELEASE OF INFORMATION

In accordance with MSA 13.05, subd. 4 (d)

I, ____,
authorize West Hennepin Public Safety to release criminal history data, as defined by Minnesota Statute 13.87, subd. 1 and driver's license and traffic record data to the City of Maple Plain. I understand that some of this data may be classified as private data under Minnesota statutes and I hereby give my informed consent to the release of that private data with West Hennepin Public Safety to the City of Maple Plain.

The consent for the release of data is for the purpose of obtaining a permit or license with the City of Maple Plain. This information cannot be used for any other purposes. This authorization may be revoked in writing by me at any time and in no event will it be valid for more than one year from the date below.

____ ______________

Signature of Individual Authorizing Release Date

COMPLETE THE FOLLOWING INFORMATION

NAME (FIRST MIDDLE LAST):

HOME ADDRESS:

Driver's License (Provide photo copy of license and license number):

Other Name Applicant may be known as:

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I certify that all statements from me on this form are true and complete. I understand that any false statements or omissions on this form shall be sufficient cause for rejection of my permit or license.

I hereby authorize the City of Maple Plain to use this information to determine my suitability for obtaining a license or permit.

I understand that my establishment is eligible for a building inspection at least once a year.

I understand that if there are complaints about my establishment or individuals working in my establishment, my license may be subject to being revoked.

Signature of applicant	**Date**

1620 MAPLE AVENUE | P.O. BOX 97 | MAPLE PLAIN, MN 55359 (763) 479-0515
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CERTIFICATION OF COMPLIANCE: MINNESOTA WORKERS' COMPENSATION LAW

Minnesota Statute, Section 176.182 requires ever state and local licensing agency to withhold the issuance or renewal of a license or permit to operate a business or engage in an activity in Minnesota until the applicant presents acceptable evidence of compliance with the workers' compensation insurance coverage requirement of Chapter 17. The information required is the name of insurance company, the policy number and dates of the coverage or the permit to self-insure. This will be collected by the licensing agency and retained in their file.

This information is required by law, and licenses and permit to operate a business may not be issued or renewed if it is not provided and/or is falsely reported. Furthermore, if this information is not provided or falsely stated, it may result in a $2,000 penalty assessed against the applicant by the Commissioner of the Department of Labor and Industry.

Insurance Company Name:

Policy Number:

Dates of Coverage: **to**

OR

☐	**I have no employees**
☐	**I am self-insured (include permit to self-insure)**
☐	**I have no employees who are covered by the workers' compensation laws (these include spouse, parents, children and certain farm employees**

I certify that the information provided above is accurate and complete and that a valid workers' compensation policy will be kept in effect at all times as required by law.

Applicant Name:

Business Name:

Business Address:

Signature of applicant	**Date**