



City of Inver Grove Heights

APPLICATION FOR INDIVIDUAL MASSAGE THERAPIST LICENSE OR THERAPEUTIC MASSAGE BUSINESS LICENSE

8150 Barbara Ave, Inver Grove Heights, MN 55077 • (651) 450-2500 • Fax (651) 450-2502 • www.invergroveheights.org

All persons performing massage in the City of Inver Grove Heights must be licensed and meet the following requirements. Provide **proof of completion** of a program of at least 500 contact hours of combined massage therapy theory and practice training from: **1)** a school accredited by the U.S. Department of Education, (<https://ope.ed.gov/dapip/#/home>) **OR** **2)** a program accredited by the Commission On Massage Therapy Accreditation (COMTA – www.comta.org). For more information, see the Massage Therapy ordinance at https://www.sterlingcodifiers.com/codebook/index.php?book_id=542.
IMPORTANT: The licensing process may take up to 90 days to complete.

Choose Which License:	_____ Massage Therapist License - Individual	_____ Therapeutic Massage Business License
Fees:	\$175/Background Fee + \$75/Individual License Fee = \$250 TOTAL	\$500/Background Fee (Includes one therapist) + \$200/License Fee = \$700 TOTAL *Additional therapists pay the Individual License fees.
Complete Parts:	Part 1, Part 2, Part 4, Part 5	Part 1, Part 3, Part 4, Part 5, Part 6

Submit this completed form with a color copy of driver's license or government issued photo ID attached.

Part 1 ALL APPLICANTS COMPLETE PART 1						
PERSONAL INFORMATION						
First Name	Middle Name	Last Name	Place of Birth (City, State):	Date of Birth:		
Height:	Weight:	Eye Color:	Hair color:			
Residential Street Address:			City:	State:	Zip Code:	
Phone Number:	U.S. Citizen: _____Yes _____No	If non-U.S. citizen, list home country and attach proof of eligibility to work in U.S.:				
Email Address:						
Social Security Number (SSN):			Individual Tax Identification Number (ITIN) if applicable:			
List your first, middle, and/or last names you have ever used or been known by – (please copy form as needed)						
First:	Middle:	Last:				
First:	Middle:	Last:				
First:	Middle:	Last:				
List your Residences for the past Five (5) Years – (please copy form as needed)						
Street Address	City	State	Zip	From (MM/YY)	To (MM/YY)	
List Name and Address of Employer and Occupation for the past Five (5) Years – (please copy form as needed)						
Employer & Occupation	Phone Number	Street Address	City/State	Zip	From (MM/YY)	To (MM/YY)

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APPLICATION FOR THERAPEUTIC MASSAGE LICENSE

**PART 1 CONTINUED
ALL APPLICANTS COMPLETE PART 1**

Criminal History, Arrest Records, Warrant Information, and Other Relevant Records – (please copy form as needed)

Have you ever been convicted of any felony crimes or ordinance violations, other than traffic offenses?

____ Yes ____ No

If yes, list – *Attach additional sheets if necessary*

Offense	Fine/Penalty	Location (City/State)	Date of Occurrence:

Have you been convicted of violation of any federal, state, or local law relating to the operation of any business requiring a license?

____ Yes ____ No

If yes, list – *Attach additional sheets if necessary*

Offense	Fine/Penalty	Location (City/State)	Date of Occurrence:

REFERENCES

List three (3) references of good moral character who are not related to you and do not have a financial interest in the premises of the business who can attest to your character. These individuals must live within the Twin Cities Metropolitan area

Name (First/Last)	Phone Number	Street Address	State	Zip

CERTIFICATE OF PROFESSIONAL LIABILITY

Are you currently insured for professional liability to practice massage? ____ YES ____ No

If yes, list insured information- Attached Certificate of Profession Liability with \$1,000,000.00 insurance coverage

Insurer	Phone Number	Street Address	State	Zip

ADDITIONAL INFORMATION

Additional information you want to include that was not required in Part 1:

APPLICATION FOR THERAPEUTIC MASSAGE LICENSE

PART 2 ONLY MESSAGE THERAPIST LICENSE APPLICANTS COMPLETE PART 2							
THERAPEUTIC MASSAGE BUSINESS INFORMATION							
Therapeutic Massage Business Name (DBA) where applying to be an Individual Therapist:							
Street Address of Licensed Premises:				Business Contact (first and last name):			
Zip Code:	Business Phone:		Contact's Phone Number:				
THERAPEUTIC MASSAGE ACADEMIC INFORMATION							
Attach diploma/certificate of graduation showing completion of a program of at least 500 hours of certified therapeutic massage training AND certified copy of transcript of academic record from accredited institution.							
Name of School Attended:				Dates Attended:			
Street Address:				Contact (first and last name):			
Zip Code:	Business Phone:		Business Contact's Phone Number:				
INDIVIDUAL MESSAGE THERAPIST LICENSE HISTORY							
Are you currently licensed as a Massage Therapist in another city? ____ Yes ____ No							
If yes, list City's information – (please copy form as needed)							
City	Street Address			State	Zip		
Have you ever been denied or rejected for an individual Massage Therapist License? ____ Yes ____ No							
If yes, list – (please copy form as needed)							
City	Street Address			State	Zip		
Have you as an individual or as part of a corporation, partnership, association, enterprise, business or firm ever had a Massage Therapist License revoked or suspended within the last (5) years of this application? ____ Yes ____ No							
If yes, list – (please copy form as needed)							
City	Street Address			State	Zip		
Have you ever owned and/or operated a Therapeutic Massage Business? ____ Yes ____ No							
If yes, list – (please copy form as needed)							
Employer & Occupation	Phone Number	Street Address		City/State	Zip	From (MM/YY)	To (MM/YY)

APPLICATION FOR THERAPEUTIC MASSAGE LICENSE

PART 3 ONLY THERAPEUTIC MASSAGE BUSINESS LICENSE APPLICANTS COMPLETE PART 3			
TYPE OF THERAPEUTIC MASSAGE BUSINESS <i>Circle one</i>			
Individual/Sole Proprietorship	Business/Firm		Partnership
Corporation	Limited Liability Company		Other Entities
ADDITIONAL REQUIREMENTS FOR THE FOLLOWING THERAPEUTIC MASSAGE BUSINESS APPLICANTS			
Partnerships	1. All partners must complete Part 1 of application in conjunction with one (1) partner completing entire application.		
	2. Managing Partners need to be designated: <i>(please copy form as needed)</i>		
	Managing Partner (First/Last)	Title	
	3. Each Partner (General and Limited) shall have their interest disclosed: <i>(please copy form as needed)</i>		
	Partner who controls an Interest (First/Last)	Percent of Interest	
	4. Attach: 1. A true copy of the Partnership Agreement and a copy 2. A true copy of trade name under MN Statute §333.02 (Certified by the Clerk of District Court)		
Corporations and other Organizations or Entities	1. Corporation/Association/Other Organization Name		2. State of Incorporation (Must be authorized to do business in Minnesota)
	3. Attach: 1. A true copy of the certificate of incorporation and if a Foreign corporation a certificate of authority as described in MN Statute §303.02 2. Articles of Incorporation of Association Agreement 3. By-laws of the Corporation		
	4. All persons (General Manager, corporate officers, proprietor and other persons in charge) must complete Part 1 of application in conjunction with one (1) person completing entire application.		
NAME/ADDRESS OF THERAPEUTIC MASSAGE BUSINESS			
Therapeutic Massage Business Name (DBA):			
Street Address of Premises:		Business Contact (first and last name):	
Zip Code:	Business Phone:	Contact's Phone Number:	
Floor Number (if applicable):	Suite Number (if applicable):	Business Email Address & Website Address:	
MESSAGE THERAPIST BUSINESS LICENSE HISTORY			
Is the corporation, partnership, association, enterprise, business or firm currently licensed as a Massage Therapist Business in another city? ____ Yes ____ No			
If yes, list City's information – <i>(please copy form as needed)</i>			
City	Street Address	State	Zip

APPLICATION FOR THERAPEUTIC MASSAGE LICENSE

**PART 3 CONTINUED
ONLY THERAPEUTIC MASSAGE BUSINESS
LICENSE APPLICANTS COMPLETE PART 3**

Has the corporation, partnership, association, enterprise, business or firm ever been denied or rejected for a Therapeutic Massage Business License?
 Yes No

If yes, list – (please copy form as needed)

City	Street Address	State	Zip

Has the corporation, partnership, association, enterprise, business or firm ever had a Therapeutic Massage Business License revoked or suspended within the last (5) years of this application? Yes No

If yes, list – (please copy form as needed)

City	Street Address	State	Zip

BUSINESS PREMISES INFORMATION

Business premises is owned by

Owner (First/Last Name)	Phone Number	Street Address	State	Zip

Is the business premises in the construction planning phase or currently under construction? Yes
 No (the premises is already constructed)

If business premises is preexisting will there be any building changes/modifications to your work space? Yes No

If yes, explain the scope of work;

Are the business premises design plans on file with the city's building and inspections department? Yes No

If No, Attach plan/sketch showing dimensions, location of buildings, street access, parking facilities configuration, interior dimension & total floor space.

Are there any real estate taxes, personal property taxes, special assessments, or other financial claims delinquent or unpaid for the premises to be licensed? If yes, give details:

PROFESSIONAL LIABILITY

Are you currently insured for professional liability to practice massage? Yes No

If yes, list insurer information – **Attach certificate of professional liability with \$1,000,000.00 limits**

Insurer	Phone Number	Street Address	State	Zip

LIST OF THERAPISTS THAT WILL BE WORKING AT MASSAGE THERAPIST BUSINESS – (please copy form as needed)

Name (First/Last)	Contact number	Address

APPLICATION FOR THERAPEUTIC MASSAGE LICENSE

PART 4 ALL APPLICANTS COMPLETE PART 4

DATA PRIVACY ADVISORY

Complete the Attached:
Message License/Permit Applicant General Authorization and Release and Criminal History Background Check Consent Form.

Review the Attached:
Message License/Permit - Data Privacy Advisory

PART 5 ALL APPLICANTS COMPLETE PART 5

TENNESSEN WARNING AND AUTHORIZATION (VERIFICATION)

The data you furnish on this application will be used by the City of Inver Grove Heights to assess your qualifications for licensure. Disclosure of this information is voluntary. You are not legally required to provide this data; however, if you fail to do so, the City of Inver Grove Heights may be unable to process this application. Disclosure of your Social Security number, Minnesota Tax ID Number, or Individual Tax ID Number is required by Minnesota Statutes 270C.72 and your Social Security number may be requested by and released to the Department of Revenue. Upon submission of this application, all information except your Social Security Number will be public information pursuant to Minnesota Statutes, Chapter 13.

I have no intention or agreement to transfer the license to another person, or to allow any other person or entity to operate under the authority of the license.

I understand that by submitting this application as an individual and operating a massage business in the City of Inver Grove Heights, I hereby consent to allow the appropriate City personnel, or any authorized representative or agents, to inspect the licensed premises for the purpose of ensuring compliance with the law, at any time the business is occupied and/or open for business. I also understand that a denial of permission for such a lawful inspection of the premises is a violation of the license provisions.

I have received from the City of Inver Grove Heights a copy of the ordinance that regulates the activity for which I am applying for licensure and I agree to familiarize myself with the provisions of said ordinance.

I will strictly comply with all the laws of the State of Minnesota governing the rules and regulations of operating a massage business and all ordinances of the City of Inver Grove Heights. I hereby certify or declare under penalty of perjury under the laws of the State of Minnesota that I have read and understand every question in this application and that the answer to every question and in all supplemental documents submitted on behalf of this application are true and correct to the best of my knowledge, information and belief. I further understand that the giving of false information in this application, regardless of when it is discovered, and or the failure to give required pertinent information constitutes cause for the immediate revocation of any and all licenses and/or permits issued hereunder and may be grounds for prosecution for perjury. All information given is subject to verification by the State of Minnesota.

A NOTARIZED SIGNATURE IS REQUIRED IN ORDER TO PROCESS THIS APPLICATION

Signature _____ Date _____

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____ day of _____, 20_____

Signature of Notary Public My Commission expires On: _____

(Stamp)

PART 6 ONLY THERAPEUTIC MASSAGE BUSINESS LICENSE APPLICANTS COMPLETE PART 6

VCI FINANCIAL RELEASE

Complete the Attached:
Verified Credentials, Authorization To Collect, Use And Release Financial Information

Review the Attached:
Disclosure Regarding Background Investigation

APPLICATION FOR THERAPEUTIC MASSAGE LICENSE

FOR CITY USE ONLY			
Tentative Due Date:	Date received and license fee paid:	Deposit Required:	
		<input type="checkbox"/> Yes Amount collected: _____ <input type="checkbox"/> No	
Financials: <input type="checkbox"/>	Other: <input type="checkbox"/>	Other: <input type="checkbox"/>	
FOR POLICE DEPARTMENT USE ONLY			
Case File #:	Investigator:	Date assigned:	Date completed:
BACKGROUND CHECKS			
RMS <input type="checkbox"/>	CCH <input type="checkbox"/>	QDP <input type="checkbox"/>	
Third Party LE Database <input type="checkbox"/>	MyBCA <input type="checkbox"/>	Statewide Supervision <input type="checkbox"/>	
Social Media <input type="checkbox"/>	Current Employers <input type="checkbox"/>	Previous Employers <input type="checkbox"/>	
Current City of employment <input type="checkbox"/>	Past City of employment <input type="checkbox"/>	Business documents <input type="checkbox"/>	
Other: <input type="checkbox"/>	Other: <input type="checkbox"/>	Other: <input type="checkbox"/>	
Other: <input type="checkbox"/>	Other: <input type="checkbox"/>	Other: <input type="checkbox"/>	
INVESTIGATION SUMMARY			
Approval Recommended			
The investigation is complete and <i>there is nothing</i> in the background of the applicant <i>which excludes</i> them from obtaining a license (see incident report for further information).			<input type="checkbox"/>
Denial Recommended			
The investigation is complete and <i>there is information</i> in the background of the applicant <i>which excludes</i> them from obtaining a license (see incident report for further information).			<input type="checkbox"/>
CHIEF'S REVIEW			
I respectfully submit the investigation findings to the City Council for use in determining whether the applicant should be granted a new or renewed license.			
Signature: _____		Date: _____, 20__	
Chief of Police			



City of Inver Grove Heights Police Department

8150 Barbara Ave, Inver Grove Heights, MN 55077

(651) 450-2525

Fax (651) 450-2543

Massage License/Permit Data Privacy Advisory

The Minnesota Data Practices Act requires the City of Inver Grove Heights to inform you of your rights about the private data we are requesting on the **Applicant General Authorization and Release and Criminal History Background Check Consent Form**.

As part of this application, you are asked to provide private and/or confidential information about yourself that will be used to check driving history, criminal history, arrest records, warrant information, other relevant records from third party law enforcement databases.

You may refuse to provide this information. However, should you refuse; our investigation cannot be completed and will result in your application not being processed. The information you provide is public and will be used by the City of Inver Grove Heights Police Department, Licensing Department, the Inver Grove Heights City Council, and the general public.

Complete the attached: **Massage License/Permit Applicant General Authorization and Release and Criminal History Background Check Consent Form**.



City of Inver Grove Heights Police Department

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Massage License/Permit

Applicant General Authorization and Release and Criminal History Background Check Consent Form

To: The City of Inver Grove Heights, the Inver Grove Heights Police Department and the Minnesota Bureau of Criminal Apprehension:

I, _____, hereby authorize and grant my informed consent to permit you to obtain, release to and make available to the City of Inver Grove Heights and/or its agents and/or representatives, data classified as private which concerns me and which may be in or come into your possession. The data, which by my signature, I authorize to be released, consists of *both public and private* data as defined in Minnesota Statutes 13.02, Subdivision 12 and has been collected by you as a result of my contact and associations with you and/or your representatives. The information for which release is authorized includes all data which has been collected, created, received, retained or disseminated in whatever form it exists.

That information to be released may relate to my dealing with any law enforcement agency and specifically includes criminal history data that will be obtained from the MN Bureau of Criminal Apprehension.

I understand that the purpose of permitting the City of Inver Grove Heights to have access to this information is to determine my suitability for issuance of a **Massage license** from the City of Inver Grove Heights.

By signing this authorization, I hereby release the MN Bureau of Criminal Apprehension, the City of Inver Grove Heights, its officers and its agents from any and all liability resulting from the release, receipt or use of all data, regardless of accuracy.

Failure to sign this authorization form will disqualify me from receiving a City License/ Permit from the City of Inver Grove Heights.

This authorization shall be valid for the period of **one year**, but I reserve the right to, at any time prior to that expiration, cancel the written authorization by providing written notice pursuant to this consent to the City of Inver Grove Heights.

PLEASE NEATLY PRINT THE INFORMATION REQUESTED BELOW. INCOMPLETE OR ILLEGIBLE FORMS WILL BE RETURNED AND WILL SLOW YOUR APPLICATION PROCESS.

Last Name

First Name

Full Middle Name

Date of Birth (mm/dd/year)

Male/Female

Driver's License Number

Street Address

City, State, ZIP

NOTE: THIS IS A LEGALLY BINDING AUTHORIZATION. YOU MAY WISH TO CONSULT WITH A LAWYER BEFORE SIGNING.

Signature

Date

PLEASE ATTACH COPY OF YOUR DRIVER'S LICENSE, COLOR PREFERRED, WITH PICTURE OF LICENSE HOLDER AND DATA CLEARLY VISIBLE AND LEGIBLE.



8150 Barbara Avenue
Inver Grove Heights, MN 55077
www.invergroveheights.org

TAX CLEARANCE INFORMATION

TO INDIVIDUAL MASSAGE THERAPIST APPLICANT:

Pursuant to Minnesota Statute 270.72 Tax Clearance: Issuance of Licenses, the licensing authority is required to provide to the Minnesota Commissioner of Revenue your Minnesota business tax identification number and the social security number of each license applicant.

Under the Minnesota Government Data Practices Act and the Federal Privacy Act of 1974, we are required to advise you of the following regarding the use of this information:

1. This information may be used to deny the issuance, renewal, or transfer of your license in the event you owe the Minnesota Department of Revenue delinquent taxes, penalties, or interest;
2. Upon receiving this information, the licensing authority will supply it only to the Minnesota Department of Revenue. However, under the Federal Exchange of Information Agreement the Department of Revenue may supply this information to the Internal Revenue Service;
3. Failure to supply this information may jeopardize or delay the processing of your licensing issuance or renewal application.

Please supply the following information and return along with your application to the agency issuing the license. **DO NOT RETURN TO THE DEPARTMENT OF REVENUE.**

LICENSING AUTHORITY: **City of Inver Grove Heights** LICENSE RENEWAL DATE: _____

Legal Business Name: _____

Business Name (Doing Business As): _____

Business Address: _____

Business Telephone No: _____

Email: _____

BUSINESS MESSAGE APPLICANTS:

Applicant they have all qualifications of a licensee and that they will not violate any city or state laws.

Minnesota Tax Identification No: _____

If a Minnesota Tax Identification or Federal FEIN number is not required, please explain on the reverse side.

Federal Tax Identification No: _____

INDIVIDUAL MASSAGE THERAPIST

Applicant they have all qualifications of a licensee and that they will not violate any city or state laws.

Social Security No: _____

Signature _____

Position (Officer, Director, Partner, etc.) _____

Print Name _____ Date _____



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MINNESOTA GOVERNMENT DATA PRACTICES ACT
"TENNESSEN WARNING"

Data is requested from the applicant on various forms. The purpose and intended use of the requested data is to verify the applicant meets all state statute and city code provisions and, if the license or permit is approved, to verify that all required data remains current.

The following data collected, created or maintained is classified under the Minnesota Government Data Practices Act as Private data **until license approval** when the data becomes **Public**: (13.41, Subd. 4).

- 1) Data submitted by applicants (other than names and designated addresses).
- 2) Orders for hearing and findings of fact.
- 3) Conclusions of law and specification of the final disciplinary action contained in the record of the disciplinary action.
- 4) Entire record concerning the disciplinary proceeding.
- 5) License numbers.
- 6) License status.

The following data collected, created or maintained is classified as **Private**: (13.41, Subd..2).

- 1) The identity of complainants who have made reports concerning licenses or applicants which appear in inactive complaint data unless the complainant consents to the disclosure.
- 2) The nature or content of unsubstantiated complaints when the information is not maintained in anticipation of legal action.
- 3) Inactive investigative data relating to violations of statutes or rules.
- 4) The record of any disciplinary proceeding except as limited by Subd. 4.

The following data collected, created or maintained is classified as **Confidential**:(13.41, Subd. 3).

- 1) Active investigative data relating to the investigation of complaints against any license.

Under law, private data may be shared with licensing and inspection employees, approval authorities, insurance providers, law enforcement employees, contracted inspection officials, as required by court order, and City officials who have a bona fide need for it. The City of Inver Grove Heights may make any data classified as private or confidential accessible to an appropriate person or agency if the licensing agency determines that failure to make the data accessible is likely to create a clear and present danger to public health or safety.

We ask that you complete or provide all data requested on the application form(s) unless we have noted that it is not required. Refusal to supply required information may mean that your application cannot be processed.

I READ AND UNDERSTAND THE ABOVE INFORMATION REGARDING MY RIGHTS AS A SUBJECT OF GOVERNMENT DATA.

_____ Date _____
Signature of Applicant

_____ Business Name: _____
Print Name