



Town of Greenwich
Department of Health
Division of Environmental Services
(203) 987-1001
www.greenwichct.org

<input type="checkbox"/> New Facility
<input type="checkbox"/> Change of Ownership
<input type="checkbox"/> License Renewal
<input type="checkbox"/> Remodeling
License Filing Fee: _____
Fees are non-refundable

Application to Operate a Massage Establishment

INFORMATION REQUESTED ON THIS APPLICATION MUST BE COMPLETE OR APPLICATION WILL BE RETURNED. All services offered must also be listed. Any service added after a license is issued must be brought to the attention of the Department in writing prior to adding the service. At the time of filing this application, authorization will be given to verify employee information. Licenses are non-transferable.

*ADDITIONAL FACILITY LICENSE AND APPLICATION IS REQUIRED FOR BODY CARE FACILITIES

Checklist for Massage Applicants: Make sure all items have been completed and/or included

- Completed Application (Sections 1, 3, and 4. Complete Section 2 if this is an initial application). Provide ALL information requested.
- Sign Application on Page 2 and Page 4.
- Include State of CT Resale Tax ID# on application OR include a separate letter addressed to Michael Long stating that no services or items are sold which require a Resale Tax ID#
- Photo ID for Applicant (Person who signs application)
- Photo ID(s) for licensed massage therapist(s)
- Copy of massage therapist(s) State of CT Massage Therapy License(s)
- License Fee: Payable to the Town of Greenwich

SECTION 1:

Name of Facility: _____

Address: _____ City _____ State _____ Zip _____

Telephone: _____ Fax: _____ Days/Hours of Operation: _____

Email _____ (either this or Fax # is used for Public Health alerts)

Check Here if Correspondence is to be Mailed to Owner Address Below

Name of Owner (Applicant): _____

Home Address: _____ City _____ State _____ Zip _____

Home Telephone: _____

Person Responsible (if other than owner): _____

Home Address: _____ City _____ State _____ Zip _____

Home Telephone: _____

Is Ownership: Sole Proprietor _____ Corporation _____ Limited Liability Corporation (LLC) _____ Other _____

Name of Corporation _____ Address/City/St _____

Corporations must attach a list of all current directors and officers. The Department must be notified in writing when there is a corporation change of officers and directors.

Water Supply (Check One):

- Public Supply
- Private Well

Sewage Disposal (Check One):

- Town Sewer
- Septic System

Types of Massage offered: _____

Number (Quantity) of Licensed Massage Therapists: _____

Number (Quantity) of Treatment Rooms: _____

****ATTACH COPIES OF CURRENT STATE OF CONNECTICUT LICENSES**

SECTION 2: To be completed for Initial Licensing Only

For all services listed, supply the following information for initial licensing.

- List **all** Facility employees with home address, contact phone number, copies of all current State of Connecticut licenses, certificates and documentation of training (certification) for each. (Note: documents of training must include what procedures professionals have been trained in and all non-licensed/certified personnel must also be listed with job assignments).
- Medical history of all communicable diseases and a current state of health for all employees who provide skin care/treatment, massage, manicure/pedicure, and body piercing/tattooing services.
- Submit copies of Building and Fire Marshall approval (where applicable)
- Submit Consumer Protection and State of Connecticut approval and/or licensure (where applicable)

SECTION 3:

Provide The Following Additional Information and Submit a Copy of Photo ID with Proof of Age:

Date of Birth: _____ Social Security Number: _____

(Applicant must be at least 18 years of age)

State of CT Resale Tax ID Number (if applicable): _____. If not applicable then letter of advisement must be submitted with this application. See sample letter in Massage Packet.

BUSINESS/OCCUPATION OR EMPLOYMENT HISTORY

Name of Business or Occupation:	Address:	Dates:
Description of Services or Duties:		
Name of Business or Occupation:	Address:	Dates:
Description of Services or Duties:		
Name of Business or Occupation:	Address:	Dates:
Description of Services or Duties:		

Have you previously operated a Massage Establishment in Connecticut or any other state? YES () NO ()
If YES, list Name, Address, and Dates of Operation: _____

Has your license ever been Denied, Suspended, or Revoked? YES () NO ()
If YES, Why? _____

Have you ever been convicted of any offenses other than motor vehicle violations within the past ten years?
YES () NO (). If YES, state the place and date of conviction, the nature of the offense and any further
explanation. _____

**Names and addresses of persons with financial interest in Massage Establishment and amount of interest
(corporate applicants provide information for corporate officers with 10% or more interest).**

Name	Home Address / City / State / Zip	%Interest

(Attach additional information on separate sheet)

List Massage Therapists: Provide Photo ID and copy of State of CT Massage Therapist License

Name	Home Address / City / State / Zip	License No.

(Attach additional information on separate sheet)

List Other Employees:

Name	Home Address / City / State / Zip	Job Title/Description

(Attach additional information on separate sheet)

SECTION 4:

- I, the undersigned, hereby apply for a license to operate a Massage Establishment in the Town of Greenwich. If granted, I agree to give permission to the Greenwich Department of Health to inspect as often as deemed necessary, and I will abide by all provisions of State and Local regulations regarding massage establishments.

- In signing this application, I have agreed to abide by and provide the required information as outlined in Article 10 of the Town of Greenwich Massage Establishment Ordinance. In addition, I will adhere to all other applicable state and local regulations.

Name of Licensee (Applicant): _____ Title: _____
Please Print (where applicable)

Signature of Licensee _____ Date: _____

I authorize and release to the Director and to the Greenwich Police Department to seek information or references necessary to verify the information contained in the application.

Applicant's Signature _____ Date: _____

Town of Greenwich Approvals:

Police Department _____ Date: _____

Health Department _____ Date: _____

The Following Approvals as Necessary:

() Planning and Zoning _____ Date: _____

() Building Department _____ Date: _____

() Fire Department _____ Date: _____

Office Use Only

Date Application Received: _____

Date Application Forwarded to Police Department _____ Returned: _____

Date Application Forwarded to: _____ Returned: _____

Date Application Forwarded to: _____ Returned: _____