

THE COMMONWEALTH OF MASSACHUSETTS
Town of Dennis Health Department
465 Main St.
Dennisport, Ma 02639

- Message Establishment
 Message Practitioner

Application for Massage Practitioner/Establishment License

Date _____

Name of Applicant: _____

Address: _____
City Zip

Home Phone Number: ()- _____

Mailing Address (if different from above): _____
City State Zip

Business Name: _____

Business Address: _____
City State Zip

Tax ID Number: _____

Business Phone Number: ()- _____

Residential Addresses for the past 5 Years:

Personal Information:
_____ Age _____ Sex _____ Height _____ Weight _____ Hair Color _____ Eye Color

Work History: List all occupations held in the past three (3) years
Occupation: _____ Date(s): _____
Occupation: _____ Date(s): _____

List all criminal convictions, forfeiture of bond, or plea of nolo contendere excluding traffic, misdemeanor, or infraction violations:

Please list all education, training, and experience to qualify for a massage license:

Have you ever had a license or permit to practice massage suspended or revoked by any agency or board, city, county, or state? Yes: _____ No: _____

IF YES, please explain: _____

Please list the establishment(s) where you will be practicing (*Note: No practice of massage is permitted in your place of residence).

Business Name	Address	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I authorize the Dennis Health Department to seek any and all information necessary to verify the information contained in this application:

Signature of Applicant

Social Security Number

APPROVED BY: _____ DATE _____

For Office Use Only	
APPLICATION INFORMATION SUBMITTED	
Proof of authority to do business in the state of Massachusetts:	Yes _____ No _____
Proof of Graduation:/ Copy of Transcript	Yes _____ No _____
One Photograph (2"x2"):	Yes _____ No _____
Proof of medical examination by licensed physician within thirty (30) days:	Yes _____ No _____
Fee of \$50.00:	Yes _____ No: _____ Check Number: _____