Public Health
Prevent. Promote. Protect.

BBHD
BRISTOL-BURLINGTON HEALTH DISTRICT
240 Stafford Avenue, Bristol, Connecticut 06010-4617
Tel. (860) 584-7682 • Fax (860) 584-3814 • www.bbhd.org

Healthy People
Healthy Communities

BRISTOL MASSAGE LICENSE APPLICATION

Fees: Annual License: $100 for establishments with less than 4 beds/tables; $50 for each bed/table thereafter

New Establishment Plan Review fee: $100

Date:_____ Type of Services:_____
(Massage Only / Massage with Nail Salon / Massage with Hair Salon / Other)

Business Name:_____ Phone #_____

Business Address:_____

Business Owner's Name(s)/ Address/ Phone:_____

_____

Fax: _____ Email: _____

CT Tax ID #:_____ Social Security # (optional):_____

Property Owner's Name/ Address/ Phone (if different):_____

_____

Business owner's occupation or employment history 3 years prior to date of application:_____

_____

Any criminal conviction, except minor motor vehicle violations, within 10 years? ___Yes ___No

Any voluntarily suspended professional licenses, certificates or registrations by a state in anticipation of or during the pendency of an investigation or other disciplinary proceeding? ___Yes ___No

Did/do you own/operate any other Massage Business(es)? If Yes, list name of business, town and state located in:

_____

If yes, has that Massage Business license ever been denied, suspended or revoked? ___Yes ___No.

List the name(s) and address(es) of all persons having a beneficial financial interest in the massage business and the amount of each person's interest if 10% or over: _____

_____

If a corporation holds 10% or more, list the names and addressed of the corporate officers, directors and shareholders:

_____

_____

List info on all Massage Therapist(s)

Name	Home Address	CT License #
Name	Home Address	CT License #
Name	Home Address	CT License #
Name	Home Address	CT License #
Name	Home Address	CT License #

Attach copies of all CT Massage Licenses and a Government Issued Photo ID.
Any changes to the above information must be reported in writing to BBHD within 48 hours.
Upon hire of new therapist(s) or removal of existing therapist(s), notify BBHD with 48 hours.

Operational Information

Hours and Days of Operation:_____

Number of Massage Rooms:_____ Number of Massage Tables/Chairs per Massage Room:_____

Is there a sauna/steam room?_____ Are showers provided?_____ If yes, # of showers:_____

Submit a clear sketch or floor plan (bird's eye view) of the business layout. Identify and label all areas, rooms, equipment, sinks, massage tables, bathrooms, entrances and exits. Be sure there is at least one conveniently located hand wash sink, not including the sinks located in a bathroom, which is available for therapist to wash hands.

Re-usable towels, sheets or linens must be properly washed & sanitized after each customer's use *.

Do you provide towels, linens or sheets?:_____. If **yes,** check the following method you plan to use:

____An approved on-site washing machine using either hot water (min. 160°F) or an approved sanitizer.

____An off-site commercial laundry-mat (washing at home is prohibited). Provide name:_____

____An off-site commercial laundry service (pick-up and delivery). Provide service contract.

*Washing and drying at home is not permitted

I read and understand the English language or have had the opportunity to have this application translated to a language I fully understand. Under perjury of law, the information I provided above is true and accurate. I am at least 18 years of age and agree to comply with any federal, state or local laws, regulations or ordinances regarding this business and operation.

Business owner's Printed name	Signature	Date signed

********** Health District Only **********

Date paid plan review fee:_____ Date paid license fee:_____ Lic #_____

Notes:_____