CORALVILLE

MASSAGE THERAPY BUSINESS PERMIT APPLICATION

1. Establishment Name: _____
2. Establishment Address: _____
3. Company/Owner Mailing Address: _____
4. Establishment Telephone Number: _____ E-mail Address: _____
5. Name of Applicant: _____
6. Name of Office Manager (if any or different than Applicant): _____
7. Business Type (Office, Mobile, Home Based or Other): _____
8. Is business address owned or leased by applicant? _____ If leased please give property owner's name: _____

9. List the names and addresses of all persons having a financial interest in the business or the profits thereof. (In the case of a corporation, the officers, directors and persons owning or controlling ten percent interest by way of a loan, ownership, or otherwise in the business, vehicles, or the profits thereof.) Any new owner, not previously listed, controlling 50% or more requires a new application. Licenses are non-transferable.

_____

Name (Age)	Address	Phone	% Interest (Total should equal 100%)
A.			
B.			
C.			
D.			

10. Will Business Owner(s) provide massage therapy services? _____ If yes please provide State of Iowa License number(s) and expiration date(s): _____

11. INCORPORATED State of Incorporation Date
Registered Name of Corporation: _____
Corporate Registration Number (if any): _____
Registered Agent of Corporation: _____
Address of Corporate Office: _____
_____

12. Does/Has Applicant own(ed) or operate(d) other massage therapy businesses? _____ If yes, please provide dates and locations for the last 10 years: _____
_____
_____
_____

13. Liability Insurance Company Name: _____ Policy Number: _____

14. Iowa State Tax Identification Number: _____

15. Have you the applicant, owner(s), manager, or any person employed by the applicant as a Massage Therapist had any license to perform massage therapy denied, revoked or suspended in any city, county, state, or any country? _____ If yes what was the reason for the denial, revocation or suspension? _____
_____
_____
_____

16. Please provide the names of Massage Therapists who are or will be employed by the applicant and have been convicted of a sex crime as defined by Iowa Code Chapter 709, or for Prostitution as defined by Iowa Code Chapter 725, or for keeping a house of prostitution as defined by Iowa Code Chapter 657, or who is a registered sex offender, and a description of all crimes and other offenses and the disposition of those offenses, excluding simple misdemeaners:

Name (Age)	Offense	Disposition
A.		
B.		
C.		
D.		
E.		
F.		
G.		

17. Employees:

Applicant's Name:		Age:	
Address:		How Long:	
City:	State:	Zip Code:	
Phone:		Email:	
Will Applicant perform massage therapy?		If yes - State License Number:	

Manager's Name:		Age:	
Address:		How Long:	
City:	State:	Zip Code:	
Phone:		Email:	
Will Manager perform massage therapy?		If yes - provide State License Number:	

Employee Name:		Age:	
Position:		State License Number:	Expiration Date:
Address:		How Long:	
City:	State:	Zip Code:	
Phone:		Email:	

Employee Name:		Age:	
Position:		State License Number:	Expiration Date:
Address:		How Long:	
City:	State:	Zip Code:	
Phone:		Email:	

Employee Name:		Age:	
Position:		State License Number:	Expiration Date:
Address:		How Long:	
City:	State:	Zip Code:	
Phone:		Email:	

Employee Name:		Age:	
Position:		State License Number:	Expiration Date:
Address:		How Long:	
City:	State:	Zip Code:	
Phone:		Email:	

Employee Name:		Age:	
Position:		State License Number:	Expiration Date:
Address:		How Long:	
City:	State:	Zip Code:	
Phone:		Email:	

Employee Name:		Age:	
Position:		State License Number:	Expiration Date:
Address:		How Long:	
City:	State:	Zip Code:	
Phone:		Email:	

Employee Name:		Age:	
Position:		State License Number:	Expiration Date:
Address:		How Long:	
City:	State:	Zip Code:	
Phone:		Email:	

Employee Name:		Age:	
Position:		State License Number:	Expiration Date:
Address:		How Long:	
City:	State:	Zip Code:	
Phone:		Email:	

Employee Name:		Age:	
Position:		State License Number:	Expiration Date:
Address:		How Long:	
City:	State:	Zip Code:	
Phone:		Email:	

Employee Name:		Age:	
Position:		State License Number:	Expiration Date:
Address:		How Long:	
City:	State:	Zip Code:	
Phone:		Email:	

I have reviewed the application, DCI report and state certified driver's records of owners and determined that there is no information which would indicate that the issuance would be detrimental to the safety, health or welfare of residents of the City.

_____ _____

Police Chief Date

Prior to issuance the following items must be verified by the City Clerk:

A copy of a government issued photo ID of the applicant, owner(s), manager and all employees or persons present on the premises who are or will be employed to perform massage therapy. _____

Proof of current State of Iowa Massage Therapy License for all employees who are or will be employed or present on premises to perform Massage Therapy. _____

Copy of Professional Liability Insurance executed by an insurance company authorized to do business in the State of Iowa, in the amount of one-million dollars per occurrence, two-million dollars per policy year. _____

_____ _____

City Clerk Date