ROSEMOUNT

SPIRIT OF PRIDE AND PROGRESS

Checklist for Therapeutic Massage License

Failure to submit a complete application will delay your licensure

- o Copy of the Certification by the National Certification Board for Therapeutic Massage and Bodywork

  OR

- o Diploma or Certificate demonstrating at least 500 hours of training from;
  - o School approved by American Massage Therapy Association or similar reputable massage association, OR
  - o School accredited by a recognized education accrediting association or agency, OR
  - o School licensed by the state or government agency having jurisdiction over the school

- o Color Copy of Driver's License or State-Issued Identification Card (front & back)

- o Signed General Authorization & Release Form (page 5)

- o Completed State of Minnesota Applicant Information Form (page 6)

- o All Applicable Fees
  - o License Fee (Jan 1. – Dec. 31) - **$90**

MASSAGE THERAPIST LICENSE APPLICATION

City of Rosemount - Clerk's Office
2875 145th Street West, Rosemount, MN 55068
651-322-2003 ~ cityclerk@ci.rosemount.mn.us

Applicant Information:

Name _____ Other NamesYou Have Gone By _____

Address _____

Phone _____ Email _____

DL# _____ State of Issue _____

Date of Birth _____ Place of Birth _____

Name of Licensed Massage Therapy Establishment you are employed by, affiliated with, or own:

Bus. Name _____ Phone _____

Address _____ Rosemount, MN 55068

What percentage of financial interest do you have in this massage therapy business? _____

Employment History: Please list employers in the past 5 years.

Name _____ Dates _____

Address _____

Phone _____ Supervisor Name _____

Name _____ Dates _____

Address _____

Phone _____ Supervisor Name _____

Name _____ Dates _____

Address _____

Phone _____ Supervisor Name _____

Name _____ Dates _____

Address _____

Phone _____ Supervisor Name _____

Name _____ Dates _____

Address _____

Phone _____ Supervisor Name _____

Character References: Must not be related to applicant or have a financial interest in the premises. The names and addresses of two (2) persons not related to the applicant who are residents of Dakota County and who can attest to the applicant's character. Please include a third (3rd) reference in the event one of the two do not respond in a timely manner.

Name _____

Address _____

Phone _____ Relationship _____

Name _____

Address _____

Phone _____ Relationship _____

Name _____

Address _____

Phone _____ Relationship _____

Have you ever been convicted of any crime or offense of any state law or city ordinance other than traffic? If so, please indicate the nature of the crime, date, and where it was committed.

List licenses which you currently hold, formerly held, or may have an interest in (list city and associated business):

Have any of the above named licenses ever been revoked? ☐ Yes ☐ No
If yes, list dates and reasons for revocation:

Have you been denied a massage therapist license by any licensing authority? ☐ Yes ☐ No
If yes, describe:

Data Privacy Notice / Tennessen Warning:

The data you supply on this form will be used to assess your qualifications for the license. You are not legally required to provide this data, but we will not be able to grant the license without it. If a license is granted, the data you supply will constitute a public record, and copies may be issued to anyone. The data requested is needed to distinguish you from other applicants; to identify you in our license files; to verify that you are the person who applied for the license; to contact you if additional information is required; to determine if any conviction you may have is a job-related consideration affecting your suitability for the license.

Residence address and telephone number will be considered public data, and be made available to anyone unless you request this information to be private, *and* that you provide an alternative address and phone number as below:

I request that my residence address and phone number be considered private data. My alternative address and phone number are:

Alt. Address _____ Alt. Phone _____

I authorize the Rosemount Police Department to disclose to the Rosemount City Administrator, City Clerk and the Rosemount City Council all information collected as a result of the background investigation done for the purpose of evaluating the attached license application. I understand that failure to provide this release will result in a denial of my application. This consent expires 6 months from the date of the application.

Upon **approval** of this license a massage practitioner is entitled to perform on-site massage at a business, office, public gathering, or private residence on an outcall basis in addition to the business locations(s) listed.

The applicant will strictly comply with all City Code regulations as set out in the Official City Code of the City of Rosemount.

The application must be signed in the presence of a Notary Public. A Notary Public is available at City Hall.

I have read and agree to all ordinances associated with this Massage Therapist License. I certify that I have read the above questions and that the answers are true and correct to the best of my knowledge.

_____
Applicant Signature

_____
Printed Name

Subscribed and sworn to before me this _____day of _____, 20_____.

_____
Notary Public

Stamp

FOR OFFICE USE ONLY

Date Received	_____	**Investigating Officer**	_____
Amount Paid	_____	**Conclusion**	_____

GENERAL AUTHORIZATION AND RELEASE
BACKGROUND REFERENCE AND VERIFICATION

Pursuant to Minnesota Stature 13.05, Subdivision 4, Minnesota Data Practices Act

OFFICE USE ONLY			
Name of Massage Institution OR Employer			
Attention			
Address			
City/State/ZIP			
Phone		**Fax**	

I, _____, hereby authorize and grant my informed consent to permit you to release and make available to the Rosemount Police Department and/or its agents and/or representatives, data classified as private which concerns me and which may be in your possession.

The data which I authorized to be released consists of private data as defined in Minnesota Statue 13.02, subdivision 12, and has been collected by you as a result of my contact and associations with you and/or your agents and representatives. The information for which release is authorized includes all data which has been collected, created, received, retained, or disseminated in whatever form which in any way relates to my dealings with you or your agency.

I understand that the purpose of permitting the Rosemount Police Department to have access to this information is to determine my suitability for a ***Massage Therapy License*** in the city, including verification of my records and analysis by personnel of the City who may review my license application.

This authorization shall be valid for a period of six months, but I reserve the right to, at any time prior to that expiration, cancel the written authorization by providing written notice to the department or to you of that fact. I also acknowledge that a photocopy of this authorization may be used in lieu of the original and that photocopy shall be considered as valid as the original.

_____ _____

Signature Date

State of Minnesota
License Applicant Information

Under Minnesota law (M.S. 270.72), the agency issuing you this license 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 must advise you that:

- This information may be used to deny the issuance, renewal or transfer of your license if you owe the Minnesota Department of Revenue delinquent taxes, penalities, or interest;
- The licensing agency will supply it only to the Minnesota Department of Revenue. However, under the Federal Exchange of Information Act, the Department of Revenue is allowed to supply this information to the Internal Revenue Service;
- Failing to supply this information may jeopardize or delay the issuance of your license or processing your renewal application.

Please fill in the following information and return this form along with your application to the agency issuing the license. **DO NOT RETURN THIS FORM TO THE DEPARTMENT OF REVENUE.**

Please print or type

Name of license being applied for and license number (if renewal): License Number #:

Massage Theraphy License

Licensing Authority (name of city, county, or state agency issuing license):

City of Rosemount

License Renewal Date:

PERSONAL INFORMATION:

Applicant's last name, Applicant's first name and middle initial, Social Security Number

Applicant's address, City, State, Zip Code

BUSINESS INFORMATION:

Business name

Business address: Rosemount, MN 55068 (City, State, Zip Code)

Minnesota tax identification number, Federal tax identification number

If a Minnesota tax identification is not required, please explain on the reverse side of this form.

Applicant Signature:

Signature, Title, Date