City of Johnston / Johnston Police Department
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Johnston, IA 50131-0410
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APPLICATION FOR MASSAGE THERAPY BUSINESS LICENSE

Section I – General Information

- Please read this form before completing. This form must be typed or printed legibly in black ink.
- **A massage therapy business cannot offer massage therapy until the business license is issued.**
- Provide complete information. An incomplete application may delay issuance of the license.
- Enclose the appropriate license fee as indicated below. Although the fee is capped at 3 LMTs, information is required for all employees. This fee must be made in the form of a check or money order.
- Please check one of the following below indicating what type of application is being submitted.

☐ New Business - Fee: $75 License Fee/ $25 per LMT to a maximum of 3 – Maximum fee is $150.

☐ Renewal – Fee: $25 per LMT (to a maximum of 3) not listed on previously approved application. No fee if no change in ownership, business name, or services

☐ Change in Existing Licensed Business – Fee: $75 License Fee/ $25 per LMT to a maximum of 3 – Maximum fee is $150

List Change(s) Here: _____

_____

Section II – Business Information

If the individual in charge of the establishment changes for a period of more than 30 days, the new individual(s) in charge and the former individual in charge must jointly or individually notify the City of Johnston of the change. Failure to notify the City will be considered a violation.

NAME OF ESTABLISHMENT

D/B/A

BUSINESS TYPE ☐ Office ☐ Mobile ☐ Home Based ☐ Other _____

Professional Liability Insurance:

Any application for a license shall be accompanied by proof of insurance executed by an insurance company authorized to do business in the state of Iowa, in the amount of two-million dollars per occurrence, six-million dollars per policy year.

Liability insurance company is _____Policy Number_____

BUSINESS ADDRESS (STREET, CITY, STATE, ZIP)

MAILING ADDRESS, IF DIFFERENT FROM ABOVE (STREET, CITY, STATE, ZIP)

MASSAGE THERAPY BUSINESS OWNER NAME

WILL BUSINESS OWNER PROVIDE MASSAGE THERAPY SERVICES? ☐ **YES** ☐ **NO**

IF YES PROVIDE STATE OF IOWA LICENSE NUMBER: **EXPIRATION DATE:**

TELEPHONE NUMBER **FAX NUMBER**

EMAIL ADDRESS

SOCIAL SECURITY NUMBER OF OWNER

IOWA STATE TAX IDENTIFICATION NUMBER

DOES/HAS APPLICANT OWN(ED) OR OPERAT(ED) OTHER MASSAGE THERAPY BUSINESSES? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE DATES AND LOCATIONS:

Section III – Complete if Corporation or LLC

CORPORATE NAME

REGISTERED AGENT

STATE OF INCORPORATION **CORPORATE REGISTRATION NUMBER, IF ANY**

ADDRESS OF CORPORATE OFFICE (STREET, CITY, STATE, ZIP)

Section IV – IMPORTANT: A written, detailed explanation including place, date and disposition is required if the response is "yes" to any question in this section. (124.05)

HAVE YOU OR ANYONE EMPLOYED BY YOU EVER BEEN ARRESTED, CHARGED, SUBJECT TO PROSECUTION, INDICTED, FOUND GUILTY, OR ENTERED A PLEA OF GUILTY OR NOLO CONTENDRE, IN A CRIMINAL PROSECUTION UNDER THE LAWS OF ANY STATE OR OF THE UNITED STATES WHETHER OR NOT SENTENCE WAS IMPOSED? APPLICANTS MUST ANSWER "YES" EVEN IF A SUSPENDED IMPOSITION OF SENTENCE OR SUSPENDED EXECUTION OF SENTENCE WAS RECEIVED/ORDERED.

☐ YES ☐ NO

IF YES – ARE YOU CURRENTLY ON PROBATION ☐ YES ☐ NO

ALL APPLICANTS MUST COMPLETE THIS SECTION:

HAS ANY OWNER OR EMPLOYEE OF THIS ESTABLISHMENT EVER HAD HIS/HER MASSAGE THERAPY LICENSE DISCIPLINED FOR ANY CAUSE? ☐ YES ☐ NO

HAS ANY OWNER OR EMPLOYEE OF THIS ESTABLISHMENT EVER BEEN AN OWNER OF A MASSAGE BUSINESS WHICH HAS HAD ITS LICENSE DISCIPLINED? ☐ YES ☐ NO

HAS ANY OWNER OR EMPLOYEE OF THIS ESTABLISHMENT EVER BEEN THE SUBJECT OF DISCIPLINE BEFORE ANY STATE BOARD? ☐ YES ☐ NO

Section V - Employees

MANAGER NAME (IF DIFFERENT THAN OWNER LISTED IN SECTION II):	AGE:	
MANAGER ADDRESS:		HOW LONG:
CITY:	STATE:	ZIP CODE:
PHONE:	EMAIL:	FAX:
WILL MANAGER PERFORM MASSAGE THERAPY? ☐ YES ☐ NO	IF YES – PROVIDE STATE LICENSE NUMBER:	
EMPLOYEE 1 NAME:	POSITION:	AGE:
STATE LICENSE NUMBER:	EXPIRATION DATE:	
EMPLOYEE 1 ADDRESS:		HOW LONG:
CITY:	STATE:	ZIP CODE:
PHONE:	EMAIL:	
EMPLOYEE 2 NAME:	POSITION:	AGE:
STATE LICENSE NUMBER:	EXPIRATION DATE:	
EMPLOYEE 2 ADDRESS:		HOW LONG:
CITY:	STATE:	ZIP CODE:
PHONE:	EMAIL:	

EMPLOYEE 3 NAME:	POSITION:	AGE:	
STATE LICENSE NUMBER:	EXPIRATION DATE:		
EMPLOYEE 3 ADDRESS:			HOW LONG:
CITY:	STATE:		ZIP CODE:
PHONE:	EMAIL:		
EMPLOYEE 4 NAME:	POSITION:	AGE:	
STATE LICENSE NUMBER:	EXPIRATION DATE:		
EMPLOYEE 4 ADDRESS:			HOW LONG:
CITY:	STATE:		ZIP CODE:
PHONE:	EMAIL:		
EMPLOYEE 5 NAME:	POSITION:	AGE:	
STATE LICENSE NUMBER:	EXPIRATION DATE:		
EMPLOYEE 5 ADDRESS:			HOW LONG:
CITY:	STATE:		ZIP CODE:
PHONE:	EMAIL:		
EMPLOYEE 6 NAME:	POSITION:	AGE:	
STATE LICENSE NUMBER:	EXPIRATION DATE:		
EMPLOYEE 6 ADDRESS:			HOW LONG:
CITY:	STATE:		ZIP CODE:
PHONE:	EMAIL:		
EMPLOYEE 7 NAME:	POSITION:	AGE:	
STATE LICENSE NUMBER:	EXPIRATION DATE:		
EMPLOYEE 7 ADDRESS:			HOW LONG:
CITY:	STATE:		ZIP CODE:
PHONE:	EMAIL:		
EMPLOYEE 8 NAME:	POSITION:	AGE:	
STATE LICENSE NUMBER:	EXPIRATION DATE:		
EMPLOYEE 8 ADDRESS:			HOW LONG:
CITY:	STATE:		ZIP CODE:
PHONE:	EMAIL:		

USE ADDITIONAL SHEET IF MORE THAN 8 EMPLOYEES

Section VI – MUST BE SIGNED IN THE PRESENCE OF NOTARY

I hereby acknowledge that I have received and/or reviewed Chapter 124 - Massage Therapy Business Licensing, of the Johnston Code of Ordinances and am familiar with the provisions thereof.
The information I have provided on this application is truthful. I understand that the falsification or misrepresentation of information submitted with my application constitutes grounds for denial of the license. I authorize the City of Johnston to verify any and all of the information requested on this application including the ordering of criminal background checks, and to conduct any necessary investigation to assure this application complies with the City's licensing ordinances.
I understand that the information supplied on this form will become public information when received by the City of Johnston. I hereby release the City of Johnston, its agents, or others, from any liability or damage which may result from furnishing the information requested.

_____ _____
Applicant Printed Name Title

_____ _____
Applicant Signature Date

Subscribed and sworn before me by _____ on this _____ day of _____, 20____.

_____ My Commission Expires: _____
Notary Public Name

_____ (Notary Stamp)
Notary Public Signature

END OF APPLICATION

CITY OF JOHNSTON USE – DO NOT COMPLETE THIS SECTION

☐ Completed Application

☐ Liability Insurance

☐ Notarized Statement

☐ Copies of government issued ID for all persons on the premises who will be employed to perform massage therapy

☐ Application fee

- ☐ New/Change Amount:_____
- ☐ Renewal only. No Charge

Received and reviewed by: _____

Date: _____

Date to Johnston Police Department: _____