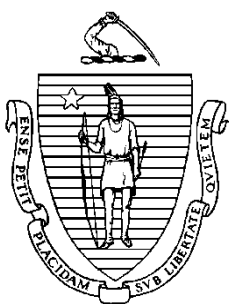


BOARD OF REGISTRATION OF MASSAGE THERAPY

Instructions for Multiple Therapist Establishment Application

1. If your establishment will have **more than one massage therapist**, then this is the correct application to submit. If your establishment will have one and only one massage therapist, then you should submit the Single Therapist Establishment Application.
2. An application must be submitted for each physical location. Additionally, should you move your establishment after licensure by the Board of Registration of Massage Therapy ("Board"), a new application must be submitted because licenses are not transferable.
3. You must read the regulations: 269 CMR 6.00 et. seq. Go to: www.mass.gov/dpl/mt and select "statutes and regulations." On the next page select "Rules and regulations governing massage therapists." On the next page select "269 CMR 6.00: Facility Licensure."
4. **If you answered Question #18(a) in the affirmative**, a certificate of standing is required from every **out-of-state** licensure jurisdiction. Certificates are required for all licensure statuses including lapsed, expired, etc. Contact that jurisdiction and have the document mailed to you for inclusion with your application. Please maintain the official **statement(s) in the unopened, jurisdiction-sealed envelope(s) to accompany your application**. The document may also be mailed directly to the Board.
5. Regarding **Question #19**, you must list all offenses including OUI, DUI, and Operating after/with suspended license or registration. Dispositions of "continued without finding" ("CWOFF") or "admission to sufficiency of facts" must be reported. Do not include minor traffic offense(s).
6. Both your application (Question#20 in its entirety) and your application checklist must be signed and notarized by all signatory parties.
7. Completed, signed and notarized **CORI Acknowledgment Form** for all signatories of this application (ie: Establishment Operator, licensed Massage Therapist, Compliance Officer and (or) Establishment Owner, see page 8 & 9).
8. Your application must include a **floor plan** highlighting the interior specifications such as dimensions of the facility. Ensure to highlight the distance of sink(s) and bathroom(s). All measurements must be recorded in "feet".
9. Your application must include a **Statement by Compliance Officer**.
10. Your application must include a compliance plan. A **sample compliance plan** is available on the Board's web site under "**applications and forms**".
11. **If your establishment is required to carry worker's comp insurance, you must provide a copy of the worker's comp insurance policy declarations page that indicates the amount and effective date of coverage**. The policy must reference the establishment. The Board cannot make recommendations about insurers nor can the board provide advice on whether your establishment is required to carry worker's comp insurance.
12. Include a check or money order for **\$150** in U.S. funds made payable to the **Commonwealth of Massachusetts**. The fee is **not** refundable. Please note that your application will not be processed without the correct fee. The initial fee includes both application processing and your first license.
13. **Mail the complete application package to: Board of Massage Therapy, 1000 Washington Street, Suite 710: Establishment Licensure, Boston, MA, 02118-6100.**
14. **Please allow 4-6 weeks for processing when all required documents have been received and approved by the board**. If you have any additional questions, please contact the Board via e-mail: MassageThearpy@mass.gov or by phone: (617) 727-3084.
15. **All new establishments will require a full inspection prior to licensure**- Establishments must be ready for business when applications are submitted, in order for full initial inspection. Inspectors **will not conduct a full inspection** during any construction (or) transition to a new location. Submission of incomplete application and/or an inspector's inability to conduct a full inspection will delay the process for licensure. Notification will be given prior to the initial inspection however, please work with the assigned inspector as exact inspection date nor time can be guaranteed in advanced. The establishment **Operator** or **Compliance Officer, or Owner** must be present for initial inspections. **Inspectors will only conduct (2) attempts for initial inspection. Failure after (2) attempt may result in denial of the application by the board.**



The Commonwealth of Massachusetts
Division of Professional Licensure
Board of Registration of Massage Therapy
1000 Washington Street, Suite 710
Boston MA 02118-6100

MULTIPLE THERAPIST ESTABLISHMENT APPLICATION

BOARD USE ONLY	
Fee (\$150): <input type="checkbox"/> Check/MO # _____	
Investigator's Name: _____	Date of Inspection: _____
Received By: _____	<input type="checkbox"/> CORI sent _____ <input type="checkbox"/> CORI rec'd: _____
Application Number _____	License Number: _____

1. Name of Establishment Operator: _____
Last First Middle

2. Massage Therapy License # (if applicable): _____

3. Name/Address of Establishment _____

No. Street P.O. Box

City/Town State Zip Code

Mailing Address (if applicable):

No. Street P.O. Box

City/Town State Zip Code

Which address should be used for mail correspondence? Establishment ☐ Mailing ☐

What is the anticipated establishment opening date (mm/dd/yyyy): ____/____/____

4. Contact Information : Day Phone: _____ Evening: _____

E-mail: _____

Please note: EMAIL will be the primary means of contact for routine correspondences during the application process.

5. Name of Compliance Officer: _____
Last First Middle

6. Massage Therapy License #: _____

7. Address of Compliance Officer: _____
No. Street P.O. Box

City/Town State Zip Code

8. Contact Information : Day Phone: _____ Evening: _____

E-mail: _____

Please note: EMAIL will be the primary means of contact for routine correspondences during the application process.

9. Establishment is: ☐ Individually Owned ☐ Partnership ☐ Incorporated or LLC (enclose articles of organization)

If a corporation or LLC, what is the name? _____

If establishment is incorporated, state where: _____

If a corporation or LLC, list names, addresses and phone numbers of the officers:

If a partnership, list names, addresses and phone numbers of the partners. _____

If individually owned, list the name, address and phone numbers of the owner? _____

10. Location of establishment: ☐ Store ☐ Residence ☐ Office Building ☐ Salon/Spa
☐ Medical Office/Clinic ☐ Physical Therapy Facility ☐ Other _____

11. (a) Will massage services be delivered off premises from the location noted on the application?
Yes: ☐ No: ☐

If yes, please provide information as to where massage services will be offered (i.e. home, hotel, medical facility, etc.)

(b) Are you exclusively offering offsite massage therapy services? Yes: ☐ No: ☐

NOTE: If you have selected "yes" as your response to questions 11(a) and (b), please proceed to skip to question #15. You will not be required to answer questions 12-14.

12. Is your establishment currently under any construction? If yes please provide anticipated date of completion ☐ Yes ☐ No

13. Has owner obtained all necessary local permits? ☐ Yes (enclose copies) ☐ No

14. Is a floor plan attached (required)? ☐ Yes ☐ No

15. Is a compliance plan attached (required)? ☐ Yes ☐ No

16. Specify how many of each of the items listed below:

Bathrooms _____ Sinks _____ Massage Tables _____ Covered Disposals _____
File/Record storage _____

17. Is this establishment required to carry Worker's Compensation insurance?

Yes: ☐ No: ☐ If "Yes," provide a copy of the Worker's Comp. insurance policy declarations page.

18. To be completed for all signatories to this application:

a) List any licenses/certifications any signatory to this application has held in the United States or any country or foreign jurisdiction and the jurisdiction from which the license/certification was originally issued. Please attach a certificate of standing from each jurisdiction outside Massachusetts in which the signatory is licensed/certified, indicating the status of the license and any relevant disciplinary information.

b) Has any disciplinary action been taken against any signatory to this application by a licensing/certification authority located in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐
If yes, please state the details, including the name of the individual, the type of license, the jurisdiction taking the disciplinary action, the reason for the discipline, and the type of discipline (use a separate sheet if necessary):

c) Is any signatory to this application the subject of pending disciplinary actions by a licensing/certification authority located in the United States or any country or foreign jurisdiction? Yes: ☐ No: ☐
If yes, please state the details, including the name of the individual, the type of license, the jurisdiction pursuing the disciplinary action, and the reason for the discipline (use a separate sheet if necessary):

d) Has any signatory to this application ever voluntarily surrendered or resigned a professional license to a licensing/certification authority in the United States or any foreign jurisdiction?
Yes: ☐ No: ☐ If yes, please state the details, including the name of the individual, the type of license, the jurisdiction for which the license was surrendered, and the reason for the surrender (use a separate sheet if necessary):

e) Has any signatory to this application ever applied for and been denied a professional license in the United States or any foreign jurisdiction? Yes: ☐ No: ☐ If yes, please state the details, including the name of the individual, the type of license, the jurisdiction in which the license was denied, and the reason for the denial (use a separate sheet if necessary):

Establishment operator or manager must notify the Board of Registration of Massage Therapy, thirty (30) days prior, of any change in ownership or location.

19. Has any signatory to this application ever been convicted of, or admitted to a felony or misdemeanor in the United States or any foreign jurisdiction, other than a traffic violation for which a fine of less than \$200.00 was assessed? Yes: ☐ No: ☐ If yes, please state the details, including the name of the individual, the jurisdiction in which the events occurred, the dates of the events and of the court decisions, the charges, the verdict(s), and the sentences (use a separate sheet if necessary): _____

NOTE: The Board has received certification by the Criminal History Systems Board (ID# MAREG G) to access data about convictions and pending criminal cases. Your signature on this application allows the Board to conduct criminal background checks for conviction, non-conviction, and pending criminal case information only, on an ongoing basis, and that it will not necessarily disqualify you from licensure (or later license renewal). Other Federal and professional records may also be checked. The Board will not deny you a license (license renewal) based on criminal information prior to giving you an opportunity for a limited appearance before the Board.

20. I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that the failure to provide accurate information may be grounds for the Massachusetts Board of Registration of Massage Therapy to deny, suspend or revoke any license issued to me in accordance with Massachusetts Law. I further attest that, pursuant to G.L. c. 62C, s. 49A., to the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by law.

Signature of Establishment Operator

Date

Birth Date & Soc. Sec. Number

Signature of Compliance Officer

Date

Birth Date & Soc. Sec. Number

Signature of Owner

Date

Birth Date & Soc. Sec. Number

(*Notarization required for each signatory on this application)

On this ____ day of _____, 20__, before me, the undersigned notary public, personally appeared _____ (name[s] of document signer[s]),
proved to me through satisfactory evidence of government issued identification, which was/were _____,
to be the person whose name is signed on the preceding or attached document,
and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose.

SEAL

Signature of Notary Public

My commission expires _____

STATEMENT BY COMPLIANCE OFFICER FOR MULTIPLE THERAPIST MASSAGE ESTABLISHMENT

I acknowledge that I am the compliance officer for the following massage establishment:

Massage Therapy Establishment License #: _____
(Leave Blank if new application)

1. I have agreed to accept the responsibilities of a compliance officer in accordance with the Massachusetts Board of Registration of Massage Therapy ("Board") regulation, 269 CMR 6.07(1).
2. I understand the laws and regulations pertaining to massage facilities and to the practice of massage therapy in Massachusetts.
3. I understand that failure to carry out the responsibilities of a compliance officer may result in discipline by the board.
4. I agree to notify the Board within 5 days of resigning my duties as compliance officer.

Name of Compliance Officer: _____
Last First Middle

Massage Therapy License #: _____

Other licenses in any jurisdiction (list state, profession, license number and current status): _____

Discipline against massage or any other professional or establishment license: _____

Information about any felony or misdemeanor, other than a traffic violation for which a fine of less than \$200.00 was assessed: (use a separate sheet if necessary): _____

Signature of Compliance Officer

Date

**YOU MUST INCLUDE THIS
APPLICATION CHECKLIST
WITH YOUR APPLICATION**

I certify, under the pains and penalties of perjury, the truth of the following statements (check all that apply):

- ☐ I have read the instructions and all regulations: 269 CMR 6.00 et. seq.
- ☐ I have enclosed a completed (signed & notarized) "License Application" form. Each and every question must be answered with the appropriate information. For "Yes/No" questions please answer "Yes," "No" or "Not Applicable"
- ☐ If applicable, I have enclosed a copy of the Articles of Organization of the owning corporation or LLC.
- ☐ I have enclosed a **CORI Acknowledgment Form** for all signatories of this application if applicable (ie: Establishment Operator, licensed Massage Therapist, Compliance Officer and (or) Establishment Owner).
- ☐ I have enclosed a **floor plan** of my establishment which includes **measurement specifications** of massage room(s) and distance to the nearest bathroom(s) and sink(s).
- ☐ I have enclosed the establishment's **compliance plan**.
- ☐ I have enclosed a signed **Statement by Compliance Officer** (page 6 of 9).
- ☐ If applicable, I have enclosed a copy of the Worker's Comp. Insurance declarations page.
- ☐ The establishment is ready for **full** inspection to be conducted by a Division of Professional Licensure inspector and is not currently under construction and ready for business.
- ☐ I have enclosed a Check/Money Order payable to: **Commonwealth of MA** for **\$150**.

MANDATORY

My Social Security Number is:

--

Tax Identification Number (FEIN) is:

--

Pursuant to G.L. c. 62C, § 47A, the Division of Professional Licensure is required to obtain your social security number/tax identification number and forward it to the Department of Revenue. The Department of Revenue will use these numbers to ascertain whether you are in compliance with the tax laws of the Commonwealth.

Signature of Operator or Owner

Date

Birth Date

On this ____ day of _____, 20__, before me, the undersigned notary public, personally appeared _____ (name of document signer), proved to me through satisfactory evidence of government issued identification, which was/were _____, to be the person whose name is signed on the preceding or attached document, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose.

SEAL

Signature of Notary Public

My commission expires _____

***Mail your application materials to: Board of Massage Therapy, 1000 Washington Street, Suite 710:
Establishment Licensure, Boston, MA, 02118-6100.***

**COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MASSAGE THERAPY
1000 Washington Street, Suite 710
Boston, MA 02118-6100
www.mass.gov/dpl/boards/mt**

**CRIMINAL OFFENDER RECORD INFORMATION (CORI)
ACKNOWLEDGEMENT FORM**

The Division of Professional Licensure by itself and on behalf of boards of registration pursuant to M.G.L. c. 13, §9 [hereinafter, "Division of Professional Licensure"] is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective license applicants and current licensees.

As a license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Services ("DCJIS"). I hereby acknowledge and provide permission to the Division of Professional Licensure to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing the Division of Professional Licensure written notice of my intent to withdraw consent to a CORI check.

FOR LICENSING PURPOSES ONLY:

The Division of Professional Licensure may conduct subsequent CORI checks within one year of the date this Form was signed by me. If subsequent CORI checks are necessary, the Division of Professional Licensure will provide me with written notice of the subsequent CORI checks.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

Signature

Date

Please provide the name of the board of registration and license type for which you are applying or currently hold:

Board of Registration

License Type

NOTE: DPL CANNOT ACCEPT THIS TWO-PAGE CORI ACKNOWLEDGMENT FORM UNLESS IT IS EITHER (1) SIGNED IN PERSON AT THE BOARD'S OFFICES IN THE PRESENCE OF A DPL EMPLOYEE WHO HAS VERIFIED THE APPLICANT'S IDENTITY THROUGH ACCEPTABLE IDENTIFICATION, OR (2) SIGNED IN THE PRESENCE OF A NOTARY PUBLIC WHO HAS LIKEWISE VERIFIED IDENTITY AND THEN MAILED OR OTHERWISE DELIVERED TO THE BOARD'S OFFICES AT THE ADDRESS SET FORTH ABOVE.

SUBJECT INFORMATION: (A red asterisk (*) denotes a required field)

*Last Name *First Name Middle Name Suffix

*Maiden Name (or other name(s) by which you have been known)

*Date of Birth Place of Birth

* Social Security Number: _____ - _____ - _____

Sex: _____ Height: _____ ft. _____ in. Eye Color: _____

Driver's License or ID Number: _____ State of Issue: _____

*Current and Former Addresses:

*Street Number & Name City/Town State Zip

*Street Number & Name City/Town State Zip

IDENTITY VERIFICATION SECTION: If this form is submitted by hand at DPL Offices, Section A must be completed. Otherwise, Section B must be completed.

SECTION A: VERIFICATION BY DPL EMPLOYEE: I hereby certify that I verified the identity of the above-referenced subject by reviewing the following form(s) of government-issued identification:¹

☐ Passport ☐ State-issued driver's license ☐ Military identification ☐ State-issued identification card

VERIFIED BY:

Name of Verifying DPL Employee (Please Print)

Signature of Verifying DPL Employee

Date

SECTION B: VERIFICATION BY NOTARY:

On this _____ day of _____, 20____, before me, the undersigned notary public, personally appeared _____ (name of document signer), and proved to me through satisfactory evidence of identification, which was the following:¹

☐ Passport ☐ State-issued driver's license ☐ Military identification ☐ State-issued identification card

to be the person whose name is signed on the preceding or attached document, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose.

Notary Public:

Notary Commission Expires On

SEAL

¹ If a subject does not have an acceptable government-issued identification, his or her identity shall be verified by other forms of documentation as determined by DCJIS. 803 CMR 2.09(2).