



# City of East Grand Forks

600 DeMers Ave · P.O. Box 373 · East Grand Forks, MN 56721  
218-773-2483 · 218-773-9728 fax    www.eastgrandforks.net

## APPLICATION FOR MASSAGE EMPLOYEE

License Fee: \_\_\_\_\_

Operating Year: \_\_\_\_\_

Applicant Information		
_____ <i>Applicant Name</i>	_____ <i>Applicant Phone Number</i>	
_____ <i>Applicant Address</i>	_____ <i>City</i>	_____ <i>State</i>
_____ <i>Zip</i>		
_____ <i>Length of time applicant has lived at above stated address</i>		
_____ <i>Citizenship</i>	_____ <i>Date of Birth</i>	
_____ <i>Occupation</i>	_____ <i>Length of time at stated occupation</i>	
_____ <i>Addresses and occupations for the three years preceding the date of application:</i>		
_____ _____ _____		
_____ <i>List four character references and their addresses if applicant has not resided in City for two years preceding the date of applicant.</i>		
_____ _____ _____		
_____ <i>State whether or not applicant has ever been convicted of a felony, gross misdemeanor or misdemeanor, including violation of a municipal ordinance but excluding traffic violations and if so, the date and place of conviction and nature of the offense.</i>		
_____ <i>DATE</i>	_____ <i>PLACE OF CONVICTION</i>	_____ <i>NATURE OF OFFENSE</i>
_____ _____	_____ _____	_____ _____
_____ <i>*Every application for a license shall be filed with the City Administrator and at the time of each original application for a business of massage parlors, there shall be paid in full an investigation fee of \$100.00. No investigation fee shall be refunded.</i>		
_____ <i>*Please provide a list of prior employers and a short resume of prior experience in the field of massage.</i>		
_____ <i>*Please provide a description of the formal training or apprenticeship, if any, in which the applicant has been involved, together with the name or names of any instructors or masters.</i>		

City of East Grand Forks  
Application for Massage Therapy License

Business Information	
_____	_____
<i>Business Name</i>	<i>Business Phone Number</i>
_____	_____
<i>Business Address</i>	<i>City State Zip</i>
_____	_____
<i>Federal Tax ID #</i>	<i>MN Tax ID #</i>

Corporate Information (if applicable)	
_____	_____
<i>Corporate Name</i>	<i>Phone Number</i>
_____	_____
<i>Corporate Address</i>	<i>City State Zip</i>

I hereby certify that I have completely filled out the entire above application, together and that the application is true, correct, and accurate.

\_\_\_\_\_

*Signature of Applicant*

\_\_\_\_\_

*Date*

\_\_\_\_\_

*Print Name*

\_\_\_\_\_

*Title*

Internal Use Only
The following items need to be completed and/or attached in order for the application to be processed:
* <input type="checkbox"/> Short resume for each employee of previous employers      * <input type="checkbox"/> Description of formal training or apprenticeship if any
* <input type="checkbox"/> Copy of certificate/degree/license of massage
* <input type="checkbox"/> Application fee paid in full & Investigation Fee Payment Type: <input type="checkbox"/> cash <input type="checkbox"/> check # _____ Receipt # _____
* <input type="checkbox"/> Application completed in full and signed:
* <input type="checkbox"/> Approved      License Number _____

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Application for Massage Therapy License

**Proof of Workers' Compensation Insurance Coverage**

Minnesota Statute Section 176.182 requires every state and local licensing agency to withhold the issuance or renewal of a license or permit to operate a business in Minnesota until the applicant presents acceptable evidence of compliance with the workers' compensation insurance coverage requirement of Section 176.181, Subd. 2. The information required is: The name of the insurance company, the policy number, and dates of coverage or the permit to self-insure. This information will be collected by the licensing agency and put in their company file. It will be furnished, upon request, to the Department of Labor and Industry to check for compliance with Minnesota Statute Sec. 176.181, Subd. 2.

This information is required by law, and licenses and permits to operate a business may not be issued or renewed if it is not provided and/or is falsely reported. Furthermore, if this information is not provided and/or falsely reported, it may result in a \$1,000 penalty assessed against the applicant by the Commissioner of the Department of Labor and Industry payable to the Special Compensation Fund.

Provide the information specified above in the spaces provided, or certify the precise reason your business is excluded from compliance with the insurance coverage requirement for workers' compensation.

Insurance Company Name: \_\_\_\_\_  
(Not the insurance agent)

Policy Number or Self-Insurance Permit Number: \_\_\_\_\_

Dates of Coverage: \_\_\_\_\_

(Or)

I am not required to have workers' compensation liability coverage because:

( ) I have no employees covered by the law.

( ) Other (specify)

I HAVE READ AND UNDERSTAND MY RIGHTS AND OBLIGATIONS WITH REGARDS TO BUSINESS LICENSES, PERMITS AND WORKERS' COMPENSATION COVERAGE, AND I CERTIFY THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT.

\_\_\_\_\_  
*Signature*