# 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

_____ _____
*Applicant Name* *Applicant Phone Number*

_____ _____
*Applicant Address* *City* *State* *Zip*

_____
*Length of time applicant has lived at above stated address*

_____ _____
*Citizenship* *Date of Birth*

_____ _____
*Occupation* *Length of time at stated occupation*

*Addresses and occupations for the three years preceding the date of application:*

_____

_____

_____

*List four character references and their addresses if applicant has not resided in City for two years preceding the date of applicant.*

_____

_____

_____

*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.*

| *DATE* | *PLACE OF CONVICTION* | *NATURE OF OFFENSE* |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**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.*

**Please provide a list of prior employers and a short resume of prior experience in the field of massage.*

**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.*

City of East Grand Forks
Application for Massage Therapy License

## Business Information

_____ _____
*Business Name* *Business Phone Number*

_____ _____
*Business Address* *City* *State* *Zip*

_____ _____
*Federal Tax ID #* *MN Tax ID #*

## Corporate Information (if applicable)

_____ _____
*Corporate Name* *Phone Number*

_____ _____
*Corporate Address* *City* *State* *Zip*

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:

*☐ Short resume for each employee of previous employers *☐Description of formal training or apprenticeship if any

*☐ Copy of certificate/degree/license of massage

*☐Application fee paid in full & Investigation Fee
Payment Type: ☐ cash ☐ check #_____ Receipt #_____

*☐Application completed in full and signed:

*☐Approved License Number _____

## 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*