TOWN OF MANCHESTER HEALTH DEPARTMENT
479 Main Street, P.O. Box 191, Manchester, CT 06045-0191
Phone Number: **(860) 647-3173**, Fax Number: **(860) 647-3188**

Application for Massage Establishment Permit

Massage Establishment Information

New ☐ **Renewal** ☐

*****(Please Print Clearly)*****

Owner/Operator Name:			
Owner/Operator Address:			
Owner/Operator City, State, Zip Code:			
Owner/Operator Phone#:		Cell Phone#:	
Date of Birth:		Age:	

Proposed Place of Business

Business Name:			
Business Street Address, City, State, Zip Code:			
Phone#:		Fax #:	
E-Mail Address:		Cell Phone#:	
Days and Hours of Operation			

Exact nature or type of massage to be administered/Other services provided

Fee New: $100.00 **Fee Renewal: $35.00**

I, _____ authorize the Director of Health to seek information and conduct an investigation into the truth of the statements set forth in this application and my qualifications for this permit. I understand that the Director of Health may require that I furnish any other identification and information necessary to discover the truth of the matter hereinbefore specified as required to be set forth in this application. I agree to operate this massage therapy establishment in accordance with the Town of Manchester Massage Establishment Ordinance. I understand that, as the applicant, I am responsible for the massage therapy establishment. I understand that any questions not answered or any false or misleading answers contained herein shall be grounds for immediate rejection of this application or closure of the massage therapy establishment registered hereunder. _____Date: _____

(Signature of applicant)

Please enclose:

- A non-refundable fee of $100 for new or $35 for a renewal
- A photocopy of the applicant's current CT Driver's License or other valid photo ID
- Photocopies of employees' State of Connecticut Massage Therapist licenses and current CT driver's licenses

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Office Use Only

Director of Health/Agent (Print):	
Signature:	Date:
Fee Paid:	Date Received:
Check#: Cash: ☐	