

BOARD OF HEALTH

18 Main St.

Hopkinton, MA 01748

TELEPHONE (508) 497-9725

Fee	Approved
License/Permit No.	

**APPLICATION FOR A MASSAGE ESTABLISHMENT LICENSE**

**MASSAGE ESTABLISHMENT MANAGER**

Full Name	Telephone ( )
MAILING ADDRESS Street number and name,	State and Zip Code

**MASSAGE ESTABLISHMENT NAME AND LOCATION**

Establishment Name:	Telephone ( )
Location Address:	
MAILING ADDRESS Street number and name, city, state and zip code	

**OWNER OF MASSAGE ESTABLISHMENT**

Full Name	Telephone ( )
Sole Proprietor _____ Partnership _____ Trust _____ Corporation _____	
MAILING ADDRESS Street number and name, city, state and zip code	

If corporation or partnership give names, titles, and home addresses of officers.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**DAYS AND HOURS OF OPERATION**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

**DATES OF OPERATION IF NOT ANNUAL:** \_\_\_\_\_

I understand that I must comply with the Board of Health regulations MASSAGE establishments and that the issuance of this permit in no way releases the applicant from the obligation to obtain any other permits or licenses required by any local, state or federal or other regulatory agency.

Pursuant to M.G.L. Ch. 62C sec. 49A, I certify under penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

Date Signed	Signature of Individual
Social Security No. or Tax Identification Number:	
Corporate Name (if applicable)	Signature of corporate officer and Title

