

BOARD OF HEALTH
 18 Main St.
 Hopkinton, MA 01748
 TELEPHONE (508) 497-9725

Fee	Approved
License/Permit No.	

APPLICATION FOR A LICENSE TO *Practice Massage Therapy*

NAME OF MASSAGE THERAPIST:

HOME ADDRESS

Location Address		Telephone ()
Mailing Address: Street number and name	City	State and Zip Code

MESSAGE SCHOOL ATTENDED

STREET ADDRESS, CITY, STATE ZIP	
DATE OF GRADUATION	TELEPHONE:

List three references that are familiar with your activities as a message therapist

1) Name:	Telephone:
Address:	
2) Name:	Telephone:
Address:	
3) Name:	Telephone:
Address:	

I certify the information I have provided above is true and accurate. 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:	
if applicable Corporate Name	Signature of corporate officer
	Title