**CITY ADMINISTRATOR'S OFFICE**
1307 Cloquet Avenue, Cloquet MN 55720
Phone: 218-879-3347 Fax: 218-879-6555
www.ci.cloquet.mn.us
email: djohnson@ci.cloquet.mn.us

# APPLICATION FOR THERAPEUTIC MASSAGE THERAPIST LICENSE

***This application, all required documentation and fees must be submitted by any person desiring to obtain a license to practice therapeutic massage within the City of Cloquet, MN.***

| APPLICANT INFORMATION | | |
|---|---|---|
| Name: First | Full Middle | Last |
| Current Address: Street / City / State / Zip Code | | |
| E-mail address: *(if applicable)* | | |
| Home Phone: | Cell Phone: | Work Phone: |
| Date of Birth: | Social Security Number: | |

| BUSINESS INFORMATION | | |
|---|---|---|
| Business where Massage Therapy Services will be conducted: | ☐ Business | ☐ *Residence |
| *A Therapeutic Massage Therapist License will only be issued to a person at a residence which is properly zoned and/or meets the zoning requirements for such location as may be required by the City. For zoning verification, contact the Cloquet Zoning Department at (218) 879-2507 prior to submitting your application. | | |
| Business Name: | Manager of Business: | |
| Business Street Address: | | |
| Phone Number: | Alternate Number: | |
| Owner of Business: | | |
| Owner's Residence Address: Street / City / State / Zip Code | | |
| Home Phone: | Cell Phone: | Work Phone: |
| E-mail address: *(if applicable)* | | |
| Property Parcel ID Number: | Property Complete Legal Description: | |

| FINANCIAL INFORMATION | | |
|---|---|---|
| Real Estate Taxes on property to be licensed are: | ☐ Paid current | ☐ Delinquent |
| Are there any financial claims to the City of Cloquet owed by the applicant /property owner? | ☐ Yes | ☐ No |

| If there are current financial claims owed to the City of Cloquet, please state the amount(s) and type of claim: | | |
|---|---|---|
| Responsible Party: | Amount: | Type of claim (i.e., utilities, etc.) |
| Responsible Party: | Amount: | Type of claim (i.e., utilities, etc.) |

**ADDITIONAL INFORMATION**
*(attach additional sheets as necessary)*

Have you ever applied for or held a license to conduct a similar activity in any other City or State? ☐ Yes ☐ No

If yes, please provide details; description, date and location:

Have you ever been denied a license to conduct a similar or like activity or had such licenses suspended, revoked or canceled in any City/State, including Cloquet? ☐ Yes ☐ No

If yes, please provide details; description, date and location:

List all names, nicknames and aliases by which you have been known:

List addresses at which you have lived during the preceding five years. Begin with present or last address and work back. *Attach additional sheets if necessary.*

Street / City / State / Zip Code

Dates at Address:

Street / City / State / Zip Code

Dates at Address:

Name, location and type of every business or occupation you have been engaged in during the preceding five years. Begin with present or last occupation and work back. *Attach additional sheets if necessary.*

Business or Occupation:

City / State / Zip Code

Dates at Address:

Business or Occupation:

City / State / Zip Code

Dates at Address:

Business or Occupation:

City / State / Zip Code

Dates at Address:

Please provide the names and addresses of your employers and partners, if any, for the preceding five years. Begin with present or last occupation and work back. *Attach additional sheets if necessary.*

Employer or Partner:

Street / City / State / Zip Code

Dates:

Employer or Partner:

Street / City / State / Zip Code

Dates:

Have you ever been convicted of any felony, crime or violation of any ordinance, other than traffic? ☐ Yes ☐ No

*If yes, give information as to the date, place, and offense for each conviction. Also, specifically state if any such conviction was a felony offense or involved any allegations of physical assault or sexual misconduct.*

List the names, residences, and business addresses of three residents of Carlton County, of good moral character, not related to the applicant or financially interested in the premises or business, who may be referred to as to the applicant's character.

Name:

Residence Address:

Business Address:

Phone Number:

Name:

Residence Address:

Business Address:

Phone Number:

Name:

Residence Address:

Business Address:

Phone Number:

**I HEREBY UNDERSTAND AND AGREE THAT:**

1. Information revealed herein for a Therapeutic Massage Therapist License in the City of Cloquet will be handled by the City in accordance with federal and state laws regarding privacy of criminal records.

2. A criminal conviction will not bar an applicant from obtaining a Therapeutic Massage Therapist License with the City of Cloquet unless such conviction is directly related to the occupation for which the license is sought, according to Minnesota Statutes §364.03.

3. Failure to reveal a criminal conviction will be considered falsification of the application and may be used as grounds for denial of the license.

(I) do hereby swear that I have submitted all of the required documentation as listed above and that the answers in this application are true and correct to the best of my knowledge. I do authorize the City of Cloquet, its agents, and employees, to obtain any necessary information and to conduct an investigation, if necessary, into the truth of the statements set forth in this application and my qualifications for this license. I do understand that providing false information shall be grounds for denial of my license.

________________________________ ____________________________

Signature of Applicant Date

Print Name________________________________________________________

First Middle Last

**SEND FUTURE APPLICATION RENEWALS TO:** ☐ Residence Address ☐ Business Address

| **FOR CITY USE ONLY:** ***(When applicable)*** | | | | |
|---|---|---|---|---|
| | **Signature:** | **Approved:** | **Denied:** | **Date:** |
| **Planning:** | | | | |
| **Police Chief:** | | | | |
| **Fire Dept.:** | | | | |
| **Finance Director:** | | | | |
| **City Administrator:** | | | | |

**THE FOLLOWING INFORMATION MUST BE SUBMITTED WITH THIS APPLICATION:**

- □ Police Records Liability Waiver

- □ Photocopy of current Minnesota Driver's License, Minnesota State Issued Identification Card or other Government issued identification as evidence that applicant is at least eighteen (18) years of age.

- □ Proof of educational requirements as outlined below:

  1. Each applicant for a massage license shall furnish with the application proof of the following:

     a. A diploma or certificate of graduation from a school approved by the American Massage Therapist Association or other similar reputable massage association.
     ***or***
     b. A diploma or certificate of graduation from a school which is either accredited by a recognized educational accrediting association or agency, or is licensed by the state or local government agency having jurisdiction over the school.

  2. The applicant for a massage therapist's license shall also provide the City and attach to its application, proof of the following:

     a. Certification or documentation verifying the fact that 500 hours of certified therapeutic massage training recognized and accepted by a national or state therapeutic massage organization has been successfully completed.
     **and**
     b. Proof of membership in good standing in a recognized national and state professional therapeutic massage organization.

- □ Proof of Professional Liability Insurance in the minimum sum of $1,000,000.

- □ If Massage Therapy services will be operated from a residence:

  - Verify with the City Zoning Department (ph. 879-2507) that property is zoned according to City Code.

  - Provide a sketch or diagram showing the configuration of the premises where the therapeutic massage business will be conducted. (The sketch or diagram need not be professionally prepared, drawn to scale, or drawn with accurate dimensions of the interior of the premises.)

- □ Authorization & Release/Data Practices Advisory Form

- □ Minnesota Business Tax Identification Law Form

- □ Appropriate Fees:

  1. One time, non-refundable **Investigation Fee of $100.00;** and

  2. **Annual Therapeutic Massage Therapist License fee of $50.00.**

| 6.9.06 Subd. 2 | All licenses shall expire on December 31 of each calendar year or portion thereof regardless of when the license was issued. |
|---|---|

**CLOQUET POLICE DEPARTMENT**
**508 Cloquet Avenue - Cloquet, MN 55720**

## P O L I C E   R E C O R D S   L I A B I L I T Y   W A I V E R

I respectfully request and expressly authorize the Cloquet Police Department to inspect criminal history records maintained on me by any and all law enforcement agencies, the Bureau of Criminal Apprehension and/or the Federal Bureau of Investigation. I further authorize the Cloquet Police Department to release any information obtained from these sources to the City of Cloquet as may be required. Information obtained in this manner is to be used solely for the purpose of determining my eligibility for the following:

**License you are applying for: Therapeutic Massage Therapist License**

| APPLICANT INFORMATION | | |
|---|---|---|
| First Name: | Full Middle Name: | Last Name: |
| Current Home Address: | | |
| City: | State: | Zip: |
| Previous Address: | | |
| City: | State: | Zip: |
| Home Phone: | Cell Phone: | Work Phone: |
| E-mail address: *(if applicable)* | | |
| Date of Birth: | Social Security Number: | |
| Driver's License Number: | | |
| Other names by which applicant has been known, including maiden name, names from previous marriages or aliases: | | |
| First Name: | Full Middle Name: | Last Name: |
| First Name: | Full Middle Name: | Last Name: |
| Business Name where massage therapy will be conducted: | | |
| Business Address: | | |
| Business Phone Number: | | |

**I hereby expressly release the Cloquet Police Department and its employees from any liability for damage to me which may result from the furnishing of such information:**

X ______________________________ ______________________________

**Signature of Individual Authorizing Release** **Date**

**(Please submit copy of Driver's License)**

## Authorization & Release

The undersigned, having filed an application with the City of Cloquet realizing that the City has need to investigate the background and history of the applicant in order to better evaluate his or her application, does hereby authorize and request every law enforcement official and every other person, firm, officer, corporation, association, organization or institution having control of any documents, records or other information pertaining to me to furnish the original or copies of any such documents, records and other information to the City or any of its representatives and to permit said City or any of its representatives to inspect and make copies of any such documents, records and other information. I further authorize any such persons to answer any inquiries, questions or interrogatories concerning the undersigned which may be submitted to them by the City or its authorized representative. I fully understand that the information so obtained by the City may be used by it in its evaluation of my application.

I hereby release and exonerate any person who shall comply with the authorization and request made herein from any and all liability of every nature and kind growing out of and in any way pertaining to the furnishing or inspection of such documents, records and other information.

## Data Practices Advisory (T*ennessen Warning)*

Some or all of the information that you are asked to provide on the attached forms are classified by state law as either private or confidential. Private data is information which generally cannot be given to the public, but can be given to the subject of the data. Confidential data is information which generally cannot be given to either the public or the subject of the data.

Our purpose and intended use of this information is to perform background investigations of the applicant, manager and others appearing on the application. This information will be used to determine if it is appropriate for the applicant to be issued a license or permit from the City of Cloquet.

You are not legally required to provide this information. However, failure to furnish the requested information may result in your application being denied.

This information will be used by various City departments in the course of their investigations. In addition, various State and Federal law enforcement agencies may be furnished portions of the information you provide.

If you have any questions in this regard, please contact the City Administrator's Office at (218) 879-3347.

I read and understand the above information regarding my rights as a subject of government data.

**I HAVE READ AND UNDERSTAND THE ABOVE**
**AUTHORIZATION & RELEASE AND DATA PRACTICES ADVISORY.**

________________________________ ________________________

Signature of Applicant Date

# MINNESOTA BUSINESS TAX IDENTIFICATION LAW

Pursuant to Minnesota Statute 270C.72 (Tax Clearance; Issuance of Licenses), Subd. 4. **The licensing authority is required to provide the Minnesota Commissioner of Revenue your business tax identification number and social security number of each license applicant. Under the Minnesota Government Data Practices Act and the Federal Privacy Act of 1974, we are required to advise you of the following regarding the use of this information:**

1. This information may be used to deny the issuance, renewal or transfer of your license in the event you owe the Minnesota Department of Revenue delinquent taxes, penalties or interest.

2. Upon receiving this information, the licensing authority will supply it only to the Minnesota Department of Revenue. However, under the Federal Exchange of Information Agreement, the Department of Revenue may supply this information to the Internal Revenue Service.

3. Failure to supply this information may jeopardize or delay the processing of your licensing issuance or renewal application.

**License Type: Therapeutic Massage Therapist License**

**Please supply the following information and return along with your application to the City of Cloquet.**

| APPLICANT INFORMATION | | |
|---|---|---|
| Name: First | Full Middle | Last |
| Current Address: | | |
| City: | State: | Zip Code: |
| Social Security Number: | | |

| MASSAGE THERAPY BUSINESS INFORMATION | | |
|---|---|---|
| Business Name: | | |
| Business Address: | | |
| City: | State: | Zip Code: |

| TAX IDENTIFICATION NUMBERS |
|---|
| Federal Tax Identification Number: |
| Minnesota Tax Identification Number: |

**Signature:** ______________________________ Date: ______________________

# Certificate of Compliance
# Minnesota Workers' Compensation Law

***THIS FORM MUST BE COMPLETED BY THE BUSINESS LICENSE APPLICANT***

**PRINT IN INK or TYPE.**

Minnesota Statutes, 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 Minnesota Statutes, Chapter 176. If the required information is not provided or is falsely stated, it shall result in a $2,000 penalty assessed against the applicant by the commissioner of the Department of Labor and Industry.

A valid workers' compensation policy must be kept in effect at all times by employers as required by law.

| LICENSE or CERTIFICATE NO (if applicable) | BUSINESS TELEPHONE NO. | FAX TELEPHONE NO. |
|---|---|---|
| BUSINESS NAME (Use the person(s) name if business structure is sole proprietor or partnership (i.e., John Doe, or John Doe and Jane Doe), otherwise it is the legal name of the business entity.) | | |
| DBA ("doing business as" or also known as an assumed name) (if applicable) | | |
| BUSINESS ADDRESS (must be physical street address, no PO boxes) | CITY | STATE ZIP CODE |
| COUNTY | E-MAIL ADDRESS | |

## YOUR LICENSE OR CERTIFICATE WILL NOT BE ISSUED WITHOUT THE FOLLOWING INFORMATION. *You must complete number 1 or 2 below.*

## NUMBER 1 – Workers' compensation insurance policy information

| INSURANCE COMPANY NAME (not the insurance agent) | | NAIC Number |
|---|---|---|
| POLICY NO. | EFFECTIVE DATE | EXPIRATION DATE |

## NUMBER 2 – Reason for exemption from workers' compensation insurance

If you have questions regarding the need to obtain workers' compensation coverage, including exemptions, contact 651.284.5032 or 1-800-342-5354.

- ☐ I have no employees. (See Minn. Stat. § 176.011, subd. 9 for the definition of an employee.)
- ☐ I am self-insured for workers' compensation (attach a copy of the authorization to self-insure from the Minnesota Department of Commerce).
- ☐ I have employees but they are not covered by the workers' compensation law. (See Minn. Stat. § 176.041 for a list of excluded employees.) Explain why your employees are not covered:

  ______________________________________________

- ☐ Other: ______________________________________

I certify that the information provided on this form is accurate and complete. If I am signing on behalf of a business, I certify that I am authorized to sign on behalf of the business.

| **PRINT NAME** | | |
|---|---|---|
| **APPLICANT SIGNATURE (required)** | **TITLE** | **DATE** |

NOTE: You must notify us if there is any change to your Workers' Compensation Insurance Information or Employee Status Change by resubmitting this form. This material can be made available in different forms, such as large print, Braille or on a tape.