

**Florida Department of Health
BOARD OF MASSAGE THERAPY**

**Massage Establishment Licensure Application
With Instructions Attached**



**Board of Massage Therapy
4052 Bald Cypress Way, #C-06
Tallahassee, FL 32399-3256
(850) 488-0595
www.flhealthsource.com**

**October 2010 Edition
Form# BMT3 Rev. 10/10**

APPLICATION FOR MESSAGE ESTABLISHMENT LICENSURE

The following instructions are in direct correlation with the application form. Please read these instructions carefully.

GENERAL INFORMATION:

The original application with fees attached should be mailed to:

BOARD OF MESSAGE THERAPY
POST OFFICE BOX 6330
TALLAHASSEE, FL 32314

Any supporting or additional documents submitted that are NOT attached to the original application must be mailed to:

Board of Massage Therapy
4052 Bald Cypress Way, Bin #C-06
Tallahassee, FL 32399-3256

- Prior to licensure you must pass an inspection by the Department of Health BEFORE you will be issued a license.
 - Once your application is deemed complete, your establishment will be flagged for an inspection.
 - Passing the inspection is NOT authorization for you to begin operation as a massage establishment.
 - You are NOT authorized to operate your establishment until you have been issued a license number.

- The Board office cannot schedule inspections. You will be notified of the date your establishment has been flagged for an inspection by the Board office. The Department's inspector will contact you to schedule your inspection within approximately 14 days of the request by Board staff.

Additional Information Required for Establishment Licensure:

1. **Application and Licensure Fees** – The fees required for initial licensure, change of name and change of location can be found directly on the application form next to the application category. These fees should be made payable to the Department of Health and should be in the form of a cashier's check or money order and should be attached to the original application when submitted.

2. **Proof of Insurance:** The owner(s) or corporation(s) are/is required to maintain property damage and bodily injury liability insurance coverage on the massage establishment.
 - Proof of insurance MUST list the exact business name, address and owner(s) of the establishment as listed on the application.
 - Only the licensed massage therapist who is the owner of the establishment may use insurance from a professional association to satisfy this requirement for establishment licensure.
 - For more information regarding types of insurance please contact a licensed insurance agent directly

3. Previous Licensure and Criminal History:

a. Certain applicant's files may need to be reviewed by the Department before a determination of licensure can be made. An application may be reviewed for a variety of reasons, such as (but not limited to):

- Criminal Convictions
- Previous Discipline
- Previous appearance before a licensing board or regulatory agency
- Drug/alcohol addiction/impairment
- Discrepancies in application information/materials
- Participation in an impaired practitioner program
- Other reasons as deemed necessary by the Board

b. The scenarios listed above are not automatically referred to the Department. An applicant's file may be sent to the Department for review. If so, you will be notified in writing of the date, time and place of the meeting.

c. It is very important that you understand the importance of these deadlines. Please refrain from making any commitments or accepting positions to practice massage therapy in Florida, as exceptions and/or special accommodations cannot be made

INSTRUCTIONS FOR COMPLETING THE APPLICATION:

SECTION I: APPLICATION CATEGORY

Please select only one application category. Please be advised that massage establishment ownership in non-transferable. If there has been a change in ownership, you cannot apply as a change of location or change of name.

SECTION II: BUSINESS PROFILE INFORMATION

1. Business Name (D/B/A) – The Doing Business As is the name in which you are doing business and the name in which the license will be issued.
2. Corporate Name – Please list the corporate name if different than the d/b/a name. If this section is not applicable, please put N/A.
3. Business Location Address – Please list the physical address of the proposed establishment or the "new" address if this is a change of location application.
4. Mailing Address – Please list the address to receive correspondence concerning this application and license. If this address is the same as the business location address, please indicate.
5. Phone Number – Please list the phone number of the proposed establishment.
6. Fax Number – Please provide the fax number of the proposed establishment.
7. FEID # or Social Security # - Please list your FEID # or the social security number of the owner if you are not a corporation or do not have a FEID #.
8. Hours of Operation – Please list the hours of operation of the proposed establishment. Please include the days of the week that the business will be open and the times of operation.
9. Will Colonics be performed? – Please answer yes or no. If colonics will be performed, please make sure that the colonics equipment is on the premises for inspection.
10. If this is a change of location or change of name application- Please list the name, license number, owner and current address of the establishment for which you are requesting the change. If this is an initial application, please indicate N/A in this section.

SECTION III: OWNERSHIP INFORMATION

- **Type of Ownership** – Please check the box that appropriately describes the type of ownership for this establishment.

- **Name of Owner** – Please list the name(s) of the owner(s) for the proposed establishment. If this is a corporation, please list the corporate name. You can attach additional sheets as necessary.
- **Name of Authorized Corporate Representative** - Please provide the name of the individual authorized to make inquiries about or changes to this application or license (once issued).
- **Additional Phone Number** – Please provide an additional phone number so that we may contact an owner or the authorized corporate representative in the event the Board office or the inspector are unable to reach you at the establishment phone number listed.

SECTION IV: PREVIOUS LICENSURE AND CRIMINAL HISTORY

- **A - License Verification** - You must also request an official license verification(s) to be submitted to the Board directly from all State licensing boards in which you hold, or have held **any regulated professional license**. The official licensure verification must state the following:
 - Current status
 - Method of licensure (exam or endorsement)
 - Date of original licensure
 - Any discipline; if license has been disciplined please request the licensing state send directly to the board office all official disciplinary documentation
 - If you have ever had discipline on a license you must submit a self-explanation and letters of recommendation as described below in the criminal history section
- **B - Criminal History documentation** – If you answered yes to any of the criminal history questions on the application you will need to send in the following:
 - Self-explanation: A brief, legible explanation of the events and what you are doing to insure they do not occur again
 - Final Disposition: This may be obtained from the clerk of court in the county the offense occurred. You must submit this document for each offense
 - Letters of Recommendation: 3-5 professional letters of recommendation, these letters should come from supervisors or teachers. Letters from family, friends or co-workers are not considered professional

Please be advised that an affirmative answer to any of the above questions may require a board appearance or delay in licensure.

SECTION V: SIGNATURE OF APPLICANT

The application must be signed by the all owners of the establishment or the authorized corporate representative (if a corporation) of the establishment.

**STATE OF FLORIDA
APPLICATION FOR MASSAGE ESTABLISHMENT LICENSURE
BOARD OF MASSAGE THERAPY
PO Box 6330
Tallahassee, FL 32314**

SECTION I: APPLICATION CATEGORY (select only one)

- Initial Establishment Application and Licensure Fee (\$255.00)
- Change of Establishment Location Fee (\$125.00)
- Change of Establishment Name Fee (\$25.00)
- Change of Establishment Location and Name Fee (\$150.00)

SECTION II: BUSINESS PROFILE INFORMATION

Business Name (D/B/A): (as it should appear on the license)	
Corporate Name: (if different than d/b/a/ name)	
Business Location Address:	Street Address
	City, State, Zip
Mailing Address:	Street Address
	City, State, Zip
Phone Number:	Fax Number:
<p>E-Mail Notification: If you want to be notified of the status of your application by e-mail please check the yes box and write your e-mail address on the line provided below. If you chose this form of notification you will receive information regarding your application file through e-mail only. You will be responsible for checking your e-mail regularly and updating your e-mail address with the Board office at: mqa_massagetherapy@doh.state.fl.us</p> <p>I want to be notified by E-Mail only <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>E-Mail Address:</p> <p>_____</p>	
FEID # or Social Security #:	
Hours of Operation:	
Will Colonics be performed at this facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If this is a <u>change of location</u> or <u>change of name</u> application, please provide the following information for the establishment's current license:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Establishment Name: _____	
Establishment License Number: _____	
Establishment's Current Address: _____	
Owner of Establishment: _____	

SECTION III: OWNERSHIP INFORMATION

Type of Ownership: Check only one	<input type="checkbox"/> Individual <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other: _____		
Name of Owner:	_____		
If corporation, list all corporate officers: (attach additional sheets if necessary)			
Officer Name:	Officer Title:	Telephone Number:	
Name of Authorized Corporate Representative:	_____		
Additional Phone Number:	_____		

SECTION IV: PREVIOUS LICENSURE AND CRIMINAL HISTORY

A. Has any owner/officer of the proposed establishment ever held an establishment license in Florida? If yes, complete the following for each establishment owned: (attach additional sheets if necessary) Establishment Name: _____ Establishment License Number: _____ Current Status of License: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
1. Has any owner/officer ever been issued a cease and desist agreement or citation for the unlicensed practice of massage therapy or operating an establishment without a license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has any owner/officer of the proposed establishment ever had a license or certificate of registration to practice massage therapy or any other licensed profession or a massage establishment license revoked, suspended or otherwise acted against (including but not limited to probation, fine, reprimand, or surrender of a license) in a disciplinary proceeding or in response to an investigation in any state?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has any owner/officer of the proposed establishment ever had a license or certificate of registration to practice massage therapy or any other licensed profession or a massage establishment license denied for any reason in any state?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is there currently pending against any owner/officer of the proposed establishment a complaint or investigation in any state/jurisdiction for professional conduct or competence?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any owner/officer of the proposed establishment ever been a defendant in a civil litigation in which the basis of the complaint against you was an alleged negligence, malpractice, sexual misconduct or fraud?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>B. Has any owner/officer ever been convicted of, or entered a plea of guilty, nolo contendere or no contest to, a crime in any jurisdiction (other than a minor traffic offense)? <i>You must include all felonies and misdemeanors, even if adjudication was withheld by the court so that you would not have a record of conviction. Please note- Driving under the influence is NOT considered a minor traffic offense.</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>C. Pursuant to Section 456.0635(2), Florida Statutes, the following questions are being asked. If you answer yes to any of the following questions, explain on a separate sheet of paper providing accurate details and submit copies of supporting documentation.</p>	
<p>1.a. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, Chapter 817, or Chapter 893, Florida Statutes; or 21 U.S.C. ss. 801-970 or 42 U.S.C. ss.1395-1396? (If "NO", do not answer 1.b.)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>1.b. Has it been more than 15 years prior to the date of this application since the sentence and completion of any subsequent period of probation for such conviction?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>2.a. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes? (If "NO", do not answer 2.b.)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>2.b. If the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant has been terminated, has the applicant been reinstated and in good standing with the Florida Medicaid Program for the most recent five years?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3.a. Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause, pursuant to the appeals procedures established by the state or federal government, from any other state Medicaid program or the federal Medicare program? (If "NO", do not answer 3.b. and 3.c.)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3.b. Has the applicant been in good standing with a state Medicaid program or the federal Medicare program for the most recent five years?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3.c. Did the termination occur at least 20 years prior to the date of this application?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION V: SIGNATURE OF APPLICANT(S)

I / We do certify that I am/we are the person(s) referred to on the application as the Owner(s) or Corporate representative, if business is incorporated, and that the statements contained herein are true and correct in every respect. I understand that it is my/our responsibility to operate this establishment in a safe and sanitary manner and to maintain insurance coverage as required by the Board's rules. I/we further certify that I/we have read Rule Chapter 64B7, F.A.C., and that this establishment meets the requirements of this rule chapter.

Printed Name	Signature	Date
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Printed Name	Signature	Date
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Printed Name	Signature	Date
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Printed Name	Signature	Date
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Printed Name	Signature	Date
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* Please attach additional sheets if additional space is needed for owner signatures.