City of Boone

923 8th Street
Boone, IA 50036

Phone (515) 432-3456

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APPLICATION FOR MASSAGE THERAPY BUSINESS LICENSE

Section I – General Information

- Please read this form before completing.
- Provide complete information. Information is required for all employees. An incomplete application may delay issuance of the license.
- Enclose the appropriate license fee for initial licensing only. **The license fee is $50.** This fee must be made in the form of cash or check.
- **A massage therapy business cannot offer massage therapy in the City of Boone until the business license is issued.**

Section II – Business Information

If the individual in charge of the establishment changes for a period of more than 30 days, the new individual(s) in charge and the former individual in charge must jointly or individually notify the City of Boone of the change. Failure to notify the City will be considered a violation.

NAME OF ESTABLISHMENT
D/B/A
BUSINESS TYPE ___ Office ___ Mobile ___ Home Based Other _____
BUSINESS ADDRESS (STREET, CITY, STATE, ZIP)
MAILING ADDRESS, IF DIFFERENT FROM ABOVE (STREET, CITY, STATE, ZIP)
MASSAGE THERAPY BUSINESS OWNER NAME
WILL BUSINESS OWNER PROVIDE MASSAGE THERAPY SERVICES? **YES** **NO** **IF YES PROVIDE STATE OF IOWA LICENSE NUMBER:** **EXPIRATION DATE:**
TELEPHONE NUMBER **FAX NUMBER**
EMAIL ADDRESS
SOCIAL SECURITY NUMBER OF OWNER
IOWA STATE TAX IDENTIFICATION NUMBER

DOES/HAS APPLICANT OWN(ED) OR OPERAT(ED) OTHER MASSAGE THERAPY BUSINESSES? **YES** **NO**

IF YES, PLEASE PROVIDE DATES AND LOCATIONS:

Section III – Complete if Corporation or LLC

CORPORATE NAME	
REGISTERED AGENT	
STATE OF INCORPORATION	**CORPORATE REGISTRATION NUMBER, IF ANY**
ADDRESS OF CORPORATE OFFICE (STREET, CITY, STATE, ZIP)	

Section IV – IMPORTANT: A written, detailed explanation including place, date and disposition is required if the response is "yes" to any question in this section.

HAVE YOU OR ANYONE EMPLOYED BY YOU EVER BEEN ARRESTED, CHARGED, SUBJECT TO PROSECUTION, INDICTED, FOUND GUILTY, OR ENTERED A PLEA OF GUILTY OR NOLO CONTENDRE, IN A CRIMINAL PROSECUTION UNDER THE LAWS OF ANY STATE OR OF THE UNITED STATES WHETHER OR NOT SENTENCE WAS IMPOSED? APPLICANTS MUST ANSWER "YES" EVEN IF A SUSPENDED IMPOSITION OF SENTENCE OR SUSPENDED EXECUTION OF SENTENCE WAS RECEIVED/ORDERED.

YES NO

IF YES – ARE YOU CURRENTLY ON PROBATION YES NO

ALL APPLICANTS MUST COMPLETE THIS SECTION:

HAS ANY OWNER OR EMPLOYEE OF THIS ESTABLISHMENT EVER HAD HIS/HER MASSAGE THERAPY LICENSE DISCIPLINED FOR ANY CAUSE? YES NO

HAS ANY OWNER OR EMPLOYEE OF THIS ESTABLISHMENT EVER BEEN AN OWNER OF A MASSAGE BUSINESS WHICH HAS HAD ITS LICENSE DISCIPLINED? YES NO

HAS ANY OWNER OR EMPLOYEE OF THIS ESTABLISHMENT EVER BEEN THE SUBJECT OF DISCIPLINE BEFORE ANY STATE BOARD? YES NO

Section V - Employees

MANAGER NAME (IF DIFFERENT THAN OWNER LISTED IN SECTION II):	AGE:	
MANAGER ADDRESS:		HOW LONG:
CITY:	STATE:	ZIP CODE:
PHONE:	EMAIL:	FAX:
WILL MANAGER PERFORM MASSAGE THERAPY? YES NO	IF YES – PROVIDE STATE LICENSE NUMBER:	
EMPLOYEE 1 NAME: POSITION:	AGE:	
STATE LICENSE NUMBER:	EXPIRATION DATE:	
EMPLOYEE 1 ADDRESS:		HOW LONG:
CITY:	STATE:	ZIP CODE:
PHONE:	EMAIL:	
EMPLOYEE 2 NAME: POSITION:	AGE:	
STATE LICENSE NUMBER:	EXPIRATION DATE:	
EMPLOYEE 2 ADDRESS:		HOW LONG:
CITY:	STATE:	ZIP CODE:
PHONE:	EMAIL:	

EMPLOYEE 3 NAME:	POSITION:	AGE:
STATE LICENSE NUMBER:	EXPIRATION DATE:	

EMPLOYEE 3 ADDRESS:		HOW LONG:
CITY:	STATE:	ZIP CODE:
PHONE:	EMAIL:	
EMPLOYEE 4 NAME: POSITION:	AGE:	
STATE LICENSE NUMBER:	EXPIRATION DATE:	
EMPLOYEE 4 ADDRESS:		HOW LONG:
CITY:	STATE:	ZIP CODE:
PHONE:	EMAIL:	
EMPLOYEE 5 NAME: POSITION:	AGE:	
STATE LICENSE NUMBER:	EXPIRATION DATE:	
EMPLOYEE 5 ADDRESS:		HOW LONG:
CITY:	STATE:	ZIP CODE:
PHONE:	EMAIL:	
EMPLOYEE 6 NAME: POSITION:	AGE:	
STATE LICENSE NUMBER:	EXPIRATION DATE:	
EMPLOYEE 6 ADDRESS:		HOW LONG:
CITY:	STATE:	ZIP CODE:
PHONE:	EMAIL:	
EMPLOYEE 7 NAME: POSITION:	AGE:	
STATE LICENSE NUMBER:	EXPIRATION DATE:	
EMPLOYEE 7 ADDRESS:		HOW LONG:
CITY:	STATE:	ZIP CODE:
PHONE:	EMAIL:	
EMPLOYEE 8 NAME: POSITION:	AGE:	
STATE LICENSE NUMBER:	EXPIRATION DATE:	
EMPLOYEE 8 ADDRESS:		HOW LONG:
CITY:	STATE:	ZIP CODE:
PHONE:	EMAIL:	

Use additional sheet if more than 8 employees

Section VI – MUST BE SIGNED IN THE PRESENCE OF NOTARY

I hereby acknowledge that I have received and/or reviewed Chapter 134 - Massage Therapy Business Licensing, of the Boone Code of Ordinances and am familiar with the provisions thereof.

The information I have provided on this application is truthful. I understand that the falsification or misrepresentation of information submitted with my application constitutes grounds for denial of the license. I authorize the City of Boone to verify any and all of the information requested on this application including the ordering of criminal background checks, and to conduct any necessary investigation to assure this application complies with the City's licensing ordinances.

I understand that the information supplied on this form will become public information when received by the City of Boone. I hereby release the City of Boone, its agents, or others, from any liability or damage which may result from furnishing the information requested.

_____ _____

Applicant Printed Name Title

_____ _____

Applicant Signature Date

Subscribed and sworn before me by_____on this_____day of_____, 20____.

_____ My Commission Expires: _____

Notary Public Name

_____ (Notary Stamp)

Notary Public Signature

END OF APPLICATION

CITY OF BOONE USE – DO NOT COMPLETE THIS SECTION

- ☐ Completed Application
- ☐ Notarized Statement
- ☐ Copies of government issued ID for all persons on the premises who will be employed to perform massage therapy
- ☐ Application fee
  - ☐ New Amount:_____
  - ☐ Renewal Only

Received and reviewed by: _____

Date: _____

Date to Boone Police Department: _____