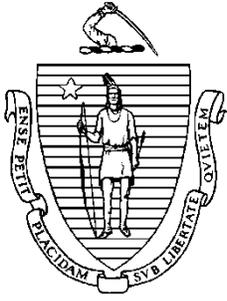


**BOARD OF REGISTRATION OF MASSAGE THERAPY**  
**Instructions for Establishment Application**

1. An application must be submitted for each physical location. Additionally, should you move your establishment after licensure by the Board of Registration of Massage Therapy (“Board”), a new application must be submitted because licenses are not transferable.
2. You must read the regulations: 269 CMR 6.00 et. seq. Go to: [www.mass.gov/dpl/mt](http://www.mass.gov/dpl/mt) and select "statutes and regulations." On the next page select "Rules and regulations governing massage therapists." On the next page select "269 CMR 6.00: Facility Licensure."
3. If you answered Question #13(a) in the affirmative, a certificate of standing is required from every **out-of-state** licensure jurisdiction. Certificates are required for all licensure statuses including lapsed, expired, etc. Contact that jurisdiction and have the document mailed to you for inclusion with your application. Please maintain the official **statement(s) in the unopened, jurisdiction-sealed envelope(s) to accompany your application.** The document may also be mailed direction to the Board; however, this may cause a delay in processing your application.
4. Regarding **Question #14**, you must list all offenses including OUI, DUI, and Operating after/with suspended license or registration. Dispositions of “continued without finding” (“CWOFF”) or “admission to sufficiency of facts” must be reported. Do not include minor traffic offense(s).
5. Your application must be signed and notarized. The checklist must also be signed and notarized.
6. Your application must include a floor plan.
7. Your multiple therapist application must include a compliance plan.
8. **If your establishment is required to carry worker’s comp insurance, you must provide a copy of the worker’s comp insurance policy declarations page that indicates the amount and effective date of coverage.** The policy must reference the establishment. The Board cannot make recommendations about insurers nor can the board provide advice on whether your establishment is required to carry worker’s comp insurance.
9. Include a check or money order for **\$50.00 (if single therapist) or \$150 (if multiple)** in U.S. funds made payable to the **Commonwealth of Massachusetts**. The fee is **not** refundable. Please note that your application will not be processed without the correct fee. The initial fee includes both application processing and your first license.
10. **Mail the complete application package to: Board of Massage Therapy, 1000 Washington Street, Suite 710: Establishment Licensure, Boston, MA, 02118-6100.**
11. **Please allow 4 – 6 weeks for processing.** If you have any additional questions, please contact the Board via email: [feiyang.chen@state.ma.us](mailto:feiyang.chen@state.ma.us) or [ana.garcia@state.ma.us](mailto:ana.garcia@state.ma.us) or by phone, (617) 727-1747.



The Commonwealth of Massachusetts  
Division of Professional Licensure  
**Board of Registration of Massage Therapy**  
1000 Washington Street, Suite 710  
Boston MA 02118-6100

**ESTABLISHMENT APPLICATION**

BOARD USE ONLY	
Fee: <input type="checkbox"/> Check/MO # _____	Amt Received: <input type="checkbox"/> \$50 (Solo) <input type="checkbox"/> \$150 (Multi)
Investigator's Name: _____	Date of Inspection: _____
Received By: _____	<input type="checkbox"/> CORI sent _____ <input type="checkbox"/> CORI rec'd: _____
Application Number _____	License Number: _____

1. Type of Establishment:  Single Therapist (Solo) -- Mass. Massage Therapist License # \_\_\_\_\_  
 More than one Therapist (Multiple) -- Name & License # of Compliance Officer \_\_\_\_\_

2. Name of Establishment Operator: \_\_\_\_\_  
Last First Middle

3. Name/Address of Establishment: \_\_\_\_\_  
No. Street P.O. Box  
City/Town State Zip Code

4. Contact Information : Day Phone: \_\_\_\_\_ Evening: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Please note: EMAIL will be the primary means of contact for routine correspondences during the application process.**

5. Establishment is:  Individually Owned  Partnership  Incorporated (enclose Articles of Corporation)

If a corporation, what is the name? \_\_\_\_\_

If establishment is incorporated, state where: \_\_\_\_\_

If a corporation, list names, addresses and phone numbers of the officers. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If a partnership, list names, addresses and phone numbers of the partners. \_\_\_\_\_  
\_\_\_\_\_

If individually owned, who is the owner? \_\_\_\_\_

6. Location of establishment:  Store  Residence  Office Building  Salon/Spa  
 Medical Office/Clinic  Physical Therapy Facility  Other \_\_\_\_\_

7. Has owner obtained all necessary local permits?  Yes  No  
8. Is a floor plan attached (required for all establishments)?  Yes  No

(If applying for a solo establishment license, skip to question #10)

9. Is a Compliance Plan attached (required for all multiple therapist establishments)?  Yes  No

(There is a sample compliance plan available on the Board's "Applications and Forms" web page)

10. How many massage therapists will be practicing at this establishment? \_\_\_\_\_  
Below list all names & MA license #'s

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11. Specify how many of each of the items listed below:

Bathrooms \_\_\_\_\_ Sinks \_\_\_\_\_ Massage Tables \_\_\_\_\_ Covered Disposals \_\_\_\_\_

12. Is this establishment required to carry Worker's Compensation insurance?

Yes:  No:  **If "Yes," provide a copy of the Worker's Comp. insurance policy declarations page.**

**13. To be completed for all signatories to this application:**

- a) List any licenses/certifications any signatory to this application has held in the United States or any country or foreign jurisdiction and the jurisdiction from which the license/certification was originally issued. Please attach a certificate of standing from each jurisdiction outside Massachusetts in which the signatory is licensed/certified, indicating the status of the license and any relevant disciplinary information.

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- b) Has any disciplinary action been taken against any signatory to this application by a licensing/certification authority located in the United States or any country or foreign jurisdiction? Yes:  No:   
If yes, please state the details (use a separate sheet if necessary): \_\_\_\_\_

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- c) Is any signatory to this application the subject of pending disciplinary actions by a licensing/certification authority located in the United States or any country or foreign jurisdiction? Yes:  No:   
If yes, please state the details (use a separate sheet if necessary): \_\_\_\_\_

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- d) Has any signatory to this application ever voluntarily surrendered or resigned a professional license to a licensing/certification authority in the United States or any foreign jurisdiction? Yes:  No:   
If yes, please state the details (use a separate sheet if necessary): \_\_\_\_\_

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- e) Has any signatory to this application ever applied for and been denied a professional license in the United States or any foreign jurisdiction? Yes:  No:  If yes, please state the details (use a separate sheet if necessary): \_\_\_\_\_

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**Establishment operator or manager must notify the Board of Registration of Massage Therapy, thirty (30) days prior, of any change in ownership or location.**

14. Has any signatory to this application ever been convicted of, or admitted to a felony or misdemeanor in the United States or any foreign jurisdiction, other than a traffic violation for which a fine of less than \$200.00 was assessed? Yes:  No:  If yes, please state the details (use a separate sheet if necessary):     

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NOTE: The Board has received certification by the Criminal History Systems Board (ID# MAREG G) to access data about convictions and pending criminal cases. Your signature on this application allows the Board to conduct criminal background checks for conviction, non-conviction, and pending criminal case information only, on an ongoing basis, and that it will not necessarily disqualify you from licensure (or later license renewal). Other Federal and professional records may also be checked. The Board will not deny you a license (license renewal) based on criminal information prior to giving you an opportunity for a limited appearance before the Board.

15. I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that the failure to provide accurate information may be grounds for the Massachusetts Board of Registration of Massage Therapy to deny, suspend or revoke any license issued to me in accordance with Massachusetts Law. I further attest that, pursuant to G.L. c. 62C, s. 49A., to the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by law.

_____ Signature of Operator	_____ Date
_____ Birth Date	ID THEFT INDEX PIN: _____ <sup>1</sup>
_____ Signature of Owner	_____ Date
_____ Birth Date	ID THEFT INDEX PIN: _____ <sup>1</sup>
_____ Signature of Owner	_____ Date
_____ Birth Date	ID THEFT INDEX PIN: _____ <sup>1</sup>

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_, before me, the undersigned notary public, personally appeared \_\_\_\_\_ (name[s] of document signer[s]), proved to me through satisfactory evidence of government issued identification, which was/were \_\_\_\_\_, to be the person whose name is signed on the preceding or attached document, and acknowledged to me that (he) (she) signed it voluntarily for its stated purpose. SEAL

\_\_\_\_\_  
Signature of Notary Public My commission expires \_\_\_\_\_

**Investigator Only:** Please staple a copy of the ITD printout for the above referenced Establishment.

**YOU MUST INCLUDE THIS  
APPLICATION CHECKLIST  
WITH YOUR APPLICATION**

I certify, under the pains and penalties of perjury, the truth of the following statements:

- I have read the instructions and all regulations: 269 CMR 6.00 et. seq.
- I have enclosed a completed (signed & notarized) "License Application" form. Each and every question must be answered with the appropriate information. For "Yes/No" questions please answer "Yes," "No" or "Not Applicable"
- If applicable, I have enclosed a copy of my local est. license, valid within the past 2 yrs.
- If applicable, I have enclosed a copy of the Articles of Corporation of the owning corporation.
- I have enclosed floor plan of my establishment which includes **measurement specifications**.
- If **Question #9** was answered in the affirmative, I have enclosed the establishment's compliance plan.
- If applicable, I have enclosed a copy of the Worker's Comp. Insurance declarations page.
- I have enclosed a Check/Money Order payable to: **Commonwealth of MA** for the following amount:  \$50 (Solo)  \$150 (Multiple)

**MANDATORY**

**My Social Security Number or Tax Identification Number is:**

-   -

Pursuant to G.L. c. 62C, § 47A, the Division of Professional Licensure is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you are in compliance with the tax laws of the Commonwealth.

\_\_\_\_\_  
Signature of Operator or Owner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Birth Date

ID THEFT INDEX PIN: \_\_\_\_\_<sup>2</sup>

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_, before me, the undersigned notary public, personally appeared \_\_\_\_\_ (name of document signer), proved to me through satisfactory evidence of government issued identification, which was/were \_\_\_\_\_, to be the person whose name is signed on the preceding or attached document, and acknowledged to me \_\_\_\_\_ SEAL that (he) (she) signed it voluntarily for its stated purpose.

\_\_\_\_\_  
Signature of Notary Public My commission expires \_\_\_\_\_

***Mail your application materials to: Board of Massage Therapy, 1000 Washington Street, Suite 710: Establishment Licensure, Boston, MA, 02118-6100.***

<sup>2</sup> Only applicable if the individual has been enrolled in the NCIC Identity Theft File by the CHSB.