



**CITY OF RICHFIELD**

**Application for  
Therapeutic Massage  
Therapist License**

**Massage Therapist Yearly Fee: \$ 97.00  
Massage Therapist Investigation Fee: \$ 100.00**

1. Therapeutic Massage Enterprise name and address where you wish to be employed:

\_\_\_\_\_  
\_\_\_\_\_

2. Name: \_\_\_\_\_  
(Last) (First) (Middle)

Maiden Name: \_\_\_\_\_

2. Residence Address: \_\_\_\_\_

\_\_\_\_\_  
(City) (State) (Zip Code)

3. Business Phone: ( ) \_\_\_\_\_ Residence Phone: ( ) \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Are you a U.S. citizen? \_\_\_\_ Yes \_\_\_\_ No

Or

Are you a Resident Alien? \_\_\_\_ Yes \_\_\_\_ No

Or

Do you have the legal authority to work in the United States? \_\_\_\_ Yes \_\_\_\_ No

If you answered "No" to above, please provide documentation establishing your ability to be legally employed in the U.S.

6. If you have ever used or been known by a name or names other than the name given above, list such name(s) and information concerning dates and places used.

\_\_\_\_\_  
\_\_\_\_\_

7. Address(es) at which you have lived during the previous five (5) years.

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8. Name, address, type and duration of employment for every business, occupation, or employer you have been engaged in during the previous five (5) years.

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10. Have you ever been convicted of any felony, crime or violation of any ordinance, other than a minor traffic offense?

Yes       No

If yes, give time, place and offense:

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11. Have you had a massage license revoked within a two (2) year period immediately preceding the date the application was submitted?

Yes       No

If Yes, explain:

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**THE CITY OF RICHFIELD WILL NOT ACCEPT APPLICATIONS  
UNLESS THE FOLLOWING REQUIRED INFORMATION IS  
ATTACHED:**

**Attach evidence that the applicant:**

1. is a member in good standing of the American Massage Therapy Association, the Associated Bodywork and Massage Professionals or other organizations of therapeutic massage professionals which has a similar written and enforceable code of ethics, and has been currently approved by the public safety director;
2. has current insurance coverage over \$1,000,000 for professional liability in the practice of massage;
3. is affiliated with, employed by or own a therapeutic massage enterprise licensed by the city;
4. has completed 400 hours of certified therapeutic massage training from a recognized school accredited by one of the national organizations described in paragraph (1);
5. has at least two years of experience practicing massage therapy.

Form  
Sp:C1

## City of Richfield License Applicant Information

Under Minnesota Law (M.S. 270C.72), the agency issuing you this license is required to provide to the Minnesota Commissioner of Revenue your Minnesota business tax identification number and the Social Security number of each license applicant.

Under the Minnesota Government Data Practices Act and the Federal Privacy Act of 1974, we must advise you that:

- This information may be used to deny the issuance, renewal, or transfer of your license if you owe the Minnesota Department of Revenue delinquent taxes, penalties, or interest;
- The licensing agency will supply it only to the Minnesota Department of Revenue. However, under the Federal Exchange of Information Act, the Department of Revenue is allowed to supply this information to the Internal Revenue Service;
- Failing to supply this information may jeopardize or delay the issuance of your license or processing your renewal application.

Please fill in the following information and return this form along with your application to the agency issuing the license. Do not return this form to the Department of Revenue.

*Please print or type*

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Name of license being applied for or renewed: \_\_\_\_\_

Licensing Authority (Name of city, county, or state agency issuing license): \_\_\_\_\_

Licensing (or renewal) date: \_\_\_\_\_

### **Personal Information:**

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|                       |                        |                             |
|-----------------------|------------------------|-----------------------------|
| Applicant's last name | First name and initial | SSN or ITIN (if applicable) |
|-----------------------|------------------------|-----------------------------|

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|                     |      |       |          |
|---------------------|------|-------|----------|
| Applicant's address | City | State | Zip Code |
|---------------------|------|-------|----------|

### **Business Information (if applicable):**

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Business name

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|                  |      |       |          |
|------------------|------|-------|----------|
| Business address | City | State | Zip Code |
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|                                     |                                   |
|-------------------------------------|-----------------------------------|
| Minnesota tax identification number | Federal tax identification number |
|-------------------------------------|-----------------------------------|

*If a Minnesota tax identification number is not required, please explain on the reverse side of this form.*

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|           |       |      |
|-----------|-------|------|
| Signature | Title | Date |
|-----------|-------|------|

Business Licensing      6700 Portland Avenue S. Richfield, MN 55423      612-861-9870

**APPLICATION FOR LICENSE INVOLVING  
PRIVATE OR CONFIDENTIAL INFORMATION  
(Tennessee Warning)**

IN CONNECTION WITH YOUR REQUEST FOR A LICENSE, THE CITY HAS ASKED THAT YOU PROVIDE IT WITH INFORMATION ABOUT YOURSELF WHICH IS CLASSIFIED AS EITHER PRIVATE OR CONFIDENTIAL BY THE MINNESOTA GOVERNMENT DATA PRACTICES ACT (M.S.A 13.04). ACCORDINGLY, THE CITY IS REQUIRED TO INFORM YOU OF THE FOLLOWING:

1. The Purpose and intended use of the information requested is: To determine if you are eligible for a license from the City of Richfield.
2. You are not legally obligated to supply the requested information.
3. The known consequences of supplying the requested information is: The information, or further investigation could disclose information, which could cause your application to be denied.
4. The known consequences of refusing to supply the requested information is: Your request for a license cannot be processed.
5. The following persons and entities are authorized by law to receive the information if provided: Staff of Richfield Public Safety Department, Bureau of Criminal Apprehension, Hennepin County Warrant Office, Ramsey County Warrant Office, State of Minnesota – Driver License Section, Hennepin County Auditor, and other governmental agencies necessary to process your application.

The undersigned, by signing this notice, acknowledges that he/she has read and understood the contents of this notice.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**PROOF OF WORKERS' COMPENSATION INSURANCE COVERAGE**

Minnesota Statute 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 Section 176.181, Subd. 2. The information required is: The name of the insurance company, the policy number, and dates of coverage or the permit to self-insure. This information will be collected by the licensing agency and put in their company file. It will be furnished, upon request to the Department of Labor and Industry to check for compliance with Minnesota Statute Sec. 176.181, Subd. 2.

This information is required by law, and licenses and permits to operate a business may not be issued or renewed if it is not provided and/or is falsely reported. Furthermore, if this information is not provided and/or falsely reported, it may result in a \$1,000 penalty assessed against the applicant by the Commissioner of the Department of labor and Industry payable to the Special Compensation Fund.

Provide the information specified above in the spaces provided, or certify the precise reason your business is excluded from compliance with the insurance coverage requirement for workers' compensation.

Insurance Company Name: \_\_\_\_\_  
(NOT the insurance agency)

Policy Number or Self-Insurance Permit Number: \_\_\_\_\_

Dates of Coverage: \_\_\_\_\_

(Or)

I am not required to have workers' compensation liability coverage because:

( ) I have no employees covered by law.

( ) Other (Specify): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I HAVE READ AND UNDERSTAND MY RIGHTS AND OBLIGATIONS WITH REGARDS TO BUSINESS LICENSES, PERMITS AND WORKERS' COMPENSATION COVERAGE, AND I CERTIFY THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT.

\_\_\_\_\_  
(SIGNATURE)

\_\_\_\_\_  
(DATE)