



## COACHELLA VALLEY MODEL MASSAGE ORDINANCE

### APPLICATION FOR MASSAGE THERAPIST PERMIT

**CITY USE ONLY:**

Date Application Received: \_\_\_\_\_ Deposit Amount \_\_\_\_\_ Received By: \_\_\_\_\_

Check One:      APPROVED:                       DENIED: REASONS FOR  
DENIAL: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

By: \_\_\_\_\_ Date \_\_\_\_\_

**Applicant Information:**

Legal Name:

Last: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

List any alias or other names, including nicknames, you have used or been known by (maiden name, previous married name, etc.): \_\_\_\_\_

Business Name, if doing business under any name other than legal name shown above: \_\_\_\_\_  
\_\_\_\_\_

Current Home Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Current Business Address, if different than Home Address shown above: \_\_\_\_\_  
\_\_\_\_\_

Home Telephone: (\_\_\_\_) \_\_\_\_\_ Business Telephone: (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security or Tax Identification No.: \_\_\_\_\_

Scars, tattoo's, or other distinguishing marks: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Color of Hair: \_\_\_\_\_ Color of Eyes: \_\_\_\_\_ Sex: \_\_\_\_\_

**Prior Residences:**

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Please list all of your residences during the past 10 years. Begin with your most current residence:

Address of Residence:	City, State & Zip Code:	Dates (Mo/Yr)	
		From	To
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If you need additional space, check here and continue on back of this page.

**Other Permits:**

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1. Have you ever had a permit, license or other authority for massage services denied, suspended or revoked by any entity?  Yes  No. If yes, please explain below:

DATE	LOCATION	REASON FOR DENIAL, SUSPENSION OR REVOCATION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you need additional space, check here and continue on back of this page.

2. Have you ever been a sole proprietor, general partner, officer, director, member or employee of any massage therapy business that has had a permit, license or authority to operate a massage business denied, suspended or revoked by any entity?  Yes  No. If yes, please explain below:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you need additional space, check here and continue on back of this page.

**Experience & Employment:**

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Beginning with your most current employment, please list all jobs (including part-time, temporary, and voluntary positions) you have held for the past 10 years. If you have had intervening periods of military service or unemployment, please list those periods in sequence in the spaces provided below. Also include all current and former businesses that you have owned, operated or managed.

1. Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Dates of Employment – From: \_\_\_\_\_ To: \_\_\_\_\_  
Name of Supervisor: \_\_\_\_\_ Check One: Full-Time  Part-Time  Voluntary   
Position/Duties: \_\_\_\_\_  
Reason for Leaving: \_\_\_\_\_

2. Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Dates of Employment – From: \_\_\_\_\_ To: \_\_\_\_\_  
Name of Supervisor: \_\_\_\_\_ Check One: Full-Time  Part-Time  Voluntary   
Position/Duties: \_\_\_\_\_  
Reason for Leaving: \_\_\_\_\_

3. Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Dates of Employment – From: \_\_\_\_\_ To: \_\_\_\_\_  
Name of Supervisor: \_\_\_\_\_ Check One: Full-Time  Part-Time  Voluntary   
Position/Duties: \_\_\_\_\_  
Reason for Leaving: \_\_\_\_\_

4. Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Dates of Employment – From: \_\_\_\_\_ To: \_\_\_\_\_  
Name of Supervisor: \_\_\_\_\_ Check One: Full-Time  Part-Time  Voluntary   
Position/Duties: \_\_\_\_\_  
Reason for Leaving: \_\_\_\_\_

5. Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Dates of Employment – From: \_\_\_\_\_ To: \_\_\_\_\_  
Name of Supervisor: \_\_\_\_\_ Check One: Full-Time  Part-Time  Voluntary   
Position/Duties: \_\_\_\_\_  
Reason for Leaving: \_\_\_\_\_

If you need additional space, check here and continue on back of this page.

**Criminal History:**

With the exception of minor traffic violations, have you ever been detained, held, arrested, indicted or summoned into court as a defendant in a criminal proceeding; or been convicted, fined, imprisoned, or been placed on probation; ordered to deposit bail or collateral for the violation of any law, police regulation or ordinance?  Yes  No

If yes, list the date; nature of the offense or violation; name, location, court or place of hearing; penalty imposed or disposition of each case:

DATE	NATURE OF OFFENSE OR VIOLATION	JURISDICTION	DISPOSITION

If you need additional space, check here and continue on back of this page.

**Attachments:**

Please use the following checklist to show all items attached to this application:

- A certified letter of intent to employ from the operator of a massage therapy establishment lawfully operating within the City. Each such letter shall verify that the operator of the massage therapy establishment has reviewed the applicant’s qualifications and that the applicant has met the requirements necessary to perform massage therapy at that establishment.
- Written evidence that the applicant is at least eighteen years of age.
- A certified statement from a physician licensed to practice medicine in the United States that provides that, within 60 days prior to the date of this application, the physician has examined the applicant and has determined that the applicant is free of communicable disease. For purposes of the physician’s statement, “communicable disease” means tuberculosis, or any disease, which may be transmitted from a massage therapist to a patron through normal physical contact during the performance of massage therapy services.
- Two front-face portrait photographs taken within 30 days of the date of this application, at least two inches by two inches in size.
- Applicant’s fingerprints taken within the previous sixty (60) days by an agency approved by the City (or Permit Administrator).
- A certified copy of the therapeutic massage and bodywork credential issued by the National Certification Board for Therapeutic Massage and Bodywork **OR** a certified copy of applicant’s diploma or certificate of graduation, or equivalent documents, establishing that applicant has successfully completed a course of study for competency as a massage therapist, consisting of at least 300 hours of massage therapy training, offered by a Recognized School of Massage, as defined in the Coachella Valley Model Massage Ordinance.
- A nonrefundable application deposit fee of \$150.00 (or \$100.00 if this is a renewal application).

**Applicant's Declaration:**

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I, the undersigned applicant, declare:

1. I have read and I am familiar with and understand the provisions of the Coachella Valley Model Massage Ordinance and, if this application is approved, I agree to abide by all such provisions and any revisions that might be passed according to law.
2. I certify that all entries made by me or under my direction in this application are true, complete and correct to the best of my knowledge.
3. I voluntarily consent and authorize the City, its agents, and employees to seek information and to conduct an investigation into the truth of the statements set forth in this application and my qualifications for the permit.
4. I certify that I am not required to register as a sex offender pursuant to the California Penal Code Section 290, or any other law.
5. I certify that, within the last 5 years, I have not been convicted of any of the following conduct:
  - (a) Pandering as set forth in California Penal Code Section 266i;
  - (b) Keeping or residing in a house of ill-fame as set forth in California Penal Code Section 315;
  - (c) Keeping a house for the purpose of assignation or prostitution, or other disorderly house as set forth in California Penal Code Section 316;
  - (d) Prevailing upon a person to visit a place of illegal gambling or prostitution as set forth in California Penal Code Section 318;
  - (e) Lewd conduct as set forth in California Penal Code Section 647, subdivision (a);
  - (f) Prostitution activities as set forth in California Penal Code Section 647, subdivision (b);
  - (g) Any offense committed in any other state which, if committed or attempted in this state, would have been punishable as one or more of the offenses set forth in California Penal Code Sections 266(i), 315, 316, 318, or 647, subdivisions (a) or (b);
  - (h) Any felony offense involving the sale of any controlled substance specified in California Health and Safety Code Sections 11054, 11055, 11056, 11057, or 11058;
  - (i) Any offense committed in any other state which, if committed or attempted in this state, would have been punishable as a felony offense involving the sale of any controlled substance specified in California Health and Safety Code Sections 11054, 11055, 11056, 11057, or 11058;
  - (j) Any misdemeanor or felony offense which relates directly to the practice of massage therapy, whether as a massage therapy business owner or operator, or as a massage therapist; or
  - (k) Any felony the commission of which occurred on the premises of a massage therapy establishment.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

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

\_\_\_\_\_  
Applicant



## MEDICAL SCREENING FOR MASSAGE PERMIT

Attention Physician:

Indian Wells Municipal Code 5.26.240 (n) requires that a certified statement from a physician licensed to practice medicine in the United States that provides that the applicant has, within sixty days prior to the filing date of the application, been examined by said physician and it has been determined that the applicant is free of any communicable disease as defined in this chapter. **The definition being that the applicant is free of any communicable disease that may be transmitted to the patrons of the business establishment through the normal course of Massage Therapy.**

Applicant's Name: \_\_\_\_\_

I certify that I have examined the above named applicant and found them to be free of any contagious or communicable disease **as described above.**

The certificate **must be signed by a Physician (not a nurse or PA).**

**TB Test Results: Positive**  **Negative**

Physician's signature: \_\_\_\_\_

Physician's Name: \_\_\_\_\_  
(PLEASE PRINT)

Medical License Number: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

Office address and telephone number: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Revised Feb 2009