



Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Division of Public Health – Licensure Unit  
 P.O. Box 94986, Lincoln, Nebraska 68509-4986  
 402-471-4970 [DHHS.Licensure2117@nebraska.gov](mailto:DHHS.Licensure2117@nebraska.gov)

## Application for a Massage Therapy Establishment License or a Change in the License

**NOTE:** To obtain a massage therapy establishment, you must meet the following qualifications.

1. Employ a massage therapist(s) who holds an active license.
2. Have adequate space for providing massage therapy services.
3. Have restroom facilities.
4. Submit a sketch of the establishment.
5. Complete the attached self-evaluation inspection report showing compliance with 172 NAC 82, section 004.

SECTION A: GENERAL INFORMATION					
1	Name of Establishment:				
2	Establishment Address:	Street/PO/Route:			
		City:	State:	Zip:	
3	Telephone Number:				
4	Full Name of the Owner of the Business:				
5	Address of the Owner of the Business, if different than above:	Street/PO/Route:			
		City:	State:	Zip:	
6	If the applicant is a sole owner/proprietorship, identify the social security number of the owner (this is <b>REQUIRED INFORMATION</b> ).			SS #:	
	<p><small><a href="#">Neb. Rev. Stat. §§38-123 and 38-130</a> requires you to provide your social security number to DHHS. Although your number is not public information, DHHS may share your social security number for child support enforcement or other administrative purposes and provide it to the Department of Revenue or the Department of Labor.</small></p>				
7	Federal Identification Number (FIN) (in the event a refund is warranted)			FIN#:	
8	Business Phone #: (optional)		Business Fax #: (optional)		Owner/Business E-Mail Address: (optional)
9	Name of each Person in Control of the Business  (if space is not adequate, attach additional sheet)				
<p><b>Indicate the type of owner of this business:</b></p> <p><input type="checkbox"/> Sole proprietorship</p> <p><input type="checkbox"/> Partnership</p> <p><input type="checkbox"/> Limited 1 liability company that has only one member</p> <p><input type="checkbox"/> Limited liability company that has <b>more than</b> one member</p> <p><input type="checkbox"/> Corporation</p> <p><input type="checkbox"/> Governmental unit</p> <p><input type="checkbox"/> Other: Identify Type _____</p>					

**SECTION B: OPERATION INFORMATION**

1. **You must have a licensed massage therapist employed in order to qualify for licensure.** List below the Name and License Number of Massage Therapist(s) Who Will Be Working in the Massage Therapy Establishment:

Name:	First:	Middle/MI:	Last:	License/Temp #:
Name:	First:	Middle/MI:	Last:	License/Temp #:
Name:	First:	Middle/MI:	Last:	License/Temp #:
Name:	First:	Middle/MI:	Last:	License/Temp #:

2. **Hours of Operation** for the Establishment (list below the hours open each day).

By Appointment Only - you must list days and times that you **most likely** will to be working

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

3. What is the Anticipated **Opening Date** or effective date of a **Change in Name/Owner**? Date: \_\_\_\_\_

**SECTION C: APPLICATION CATEGORY**

<input type="checkbox"/>	<b>NEW ESTABLISHMENT OR CHANGE IN OWNER</b>
<b>FEE:</b>	\$127.00 \$31.75 if your license is issued within 180 days of the expiration date (May-Oct odd-numbered yrs)

<input type="checkbox"/>	<b>CHANGE IN NAME</b>
	Previous Name: _____
	License #: _____
<b>FEE:</b>	\$10.00

<input type="checkbox"/>	<b>CHANGE IN LOCATION</b>
	Previous Address: _____ Street/PO/Route: _____
	City: _____ State: _____ Zip: _____
	Do you plan to close the previous location listed above: _____
	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If yes, what is the effective date of such closing: _____
	License # _____
<b>FEE:</b>	\$127.00 \$31.75 if your license is issued within 180 days of the expiration date (May-Oct odd-numbered yrs)

**SECTION D: OPERATION PRIOR TO LICENSURE**

If you operate a business in Nebraska without a license, you are subject to assessment of an Administrative Penalty of \$10 per day up to \$1,000, or other action as provided in the statutes and regulations.

- No. I **have not** operated this business at this address in Nebraska prior to the application for a license.
- Yes. I **have** operated this business at this address in Nebraska prior to the application for a license.

If yes, what are the actual number of days you operated in Nebraska without a license

Number of days: \_\_\_\_\_

**SECTION E: ATTESTATION**

If the **applicant** is a **sole owner/proprietorship** for the purpose of complying with Neb. Rev. Stat. §4-108 through 4-114, the applicant must attest as follows:

I am a citizen of the United States.

**OR**

I am a qualified alien under the Federal Immigration and Nationality Act.

I am a nonimmigrant lawfully present in the United States.

I am **NOT** a citizen of the United States, a nonimmigrant, nor a qualified alien under the Federal Immigration and Nationality Act.

My immigration and alien number are as follows: \_\_\_\_\_ and I agree to attach a copy of my USCIS documentation, which includes one of the following:

1. A "Green Card" otherwise known as a Permanent Resident Card (Form I-551), both front and back of the card;
2. An unexpired foreign passport with an unexpired Temporary I-551 stamp bearing the same name as the passport;
3. A Form I-94 (Arrival-Departure Record).
4. Employment Authorization Card and DACA, pending asylum, application for protected status, or application for adjustment of status to that of an alien lawfully admitted for permanent or conditional residence.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete and accurate and I understand that this information may be used to verify my lawful presence in the United States.

**I further attest that:**

1. I have read the application or have had the application read to me; and
2. All statements on this application are true and complete.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the **applicant** is a **limited liability company with more than one member, corporation, governmental unit, or other**, the application must be signed and dated by the individual(s) indicated below

**(place a check mark in the appropriate box)**

- By the partnership or a limited 1 liability company that has only one member;
- Two of its members if the applicant is a limited liability company that has more than one member;
- Two of its officers if the applicant is a corporation;
- The head of the governmental unit having jurisdiction over the business if the applicant is a governmental unit; or
- If the applicant is not an entity described in 1 through 4 above, the owner or owners or, if there is no owner, the chief executive officer or comparable official.

**We further attest that:**

1. We have read the application or have had the application read to us; and
3. All statements on this application are true and complete.

\_\_\_\_\_  
Signature of Owner/Representative as listed above Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Owner/Representative as listed above Date \_\_\_\_\_

**LICENSURE UNIT**

P.O. BOX 94986 - LINCOLN, NEBRASKA 68509

(402) 471-4970 E-mail: [DHHS.Licensure2117@nebraska.gov](mailto:DHHS.Licensure2117@nebraska.gov)

**SELF INSPECTION REPORT  
Massage Therapy Establishment**

Establishment Name:			
Address:			
Owner:		Telephone #:	

**Hours of Operation:**

By Appointment Only

Indicate the Days open and the hours for each day:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

**Licensees:**

List the Name of Each Massage Therapist and License #	Massage Therapist		Temporary	
	Lic #	Current	Lic #	Current
		<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no
		<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no
		<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no
		<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no
		<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no
		<input type="checkbox"/> yes <input type="checkbox"/> no		<input type="checkbox"/> yes <input type="checkbox"/> no

**Establishment Signature:**

I verify that the information on the inspection report is true and complete.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Section A - Inspection:**

	Met	Not Met	Inspection Areas
<b>1</b> <b><u>Physical Structure:</u></b>	<input type="checkbox"/>	<input type="checkbox"/>	a. The massage therapy establishment has a clearly identifiable location.
	<input type="checkbox"/>	<input type="checkbox"/>	b. All rooms must have adequate lighting and ventilation.
	<input type="checkbox"/>	<input type="checkbox"/>	c. The establishment has an area that can be screened from public view for customers requesting privacy.
	<input type="checkbox"/>	<input type="checkbox"/>	d. Each room where massage therapy services are provided has an EPA registered disinfectant that is proven effective against HIV-1, or Hepatitis B, or is a Tuberculocidal, and has liquid soap and water or an instant sanitizer.
<b>2</b> <b><u>Water:</u></b>	<input type="checkbox"/>	<input type="checkbox"/>	The establishment has a supply of hot and cold running water in sufficient quantities to conduct business in the establishment in a sanitary manner.
<b>3</b> <b><u>Safety:</u></b>	<input type="checkbox"/>	<input type="checkbox"/>	a. Floors, floor coverings, walls, woodwork, ceilings, furniture, fixtures and equipment are clean and safe.
	<input type="checkbox"/>	<input type="checkbox"/>	b. Floors are free of unsafe objects and slippery or uneven surfaces.
	<input type="checkbox"/>	<input type="checkbox"/>	c. Doors, stairways, passageways, aisles, or other means of exit provide safe and adequate access.
	<input type="checkbox"/>	<input type="checkbox"/>	d. Electrical appliances or apparatus are clean and have no worn or bare wiring to avoid fires, shocks, and electrocution.
	<input type="checkbox"/>	<input type="checkbox"/>	e. Water or product spills on the floor are removed immediately and floor dried to avoid falls.
	<input type="checkbox"/>	<input type="checkbox"/>	f. If candles are used in the establishment, the candle(s) must be on a surface where they are securely supported on a substantial noncombustible base and the candle flame is protected.
<b>4</b> <b><u>Restroom Facilities:</u></b>	<input type="checkbox"/>	<input type="checkbox"/>	A restroom is available on the premise.
<b>5</b> <b><u>Massage Tables and Chairs:</u></b>	<input type="checkbox"/>	<input type="checkbox"/>	a. All tables and chairs are safe and in a sanitary condition at all times.
	<input type="checkbox"/>	<input type="checkbox"/>	b. Tables/chairs with no sheeting/pad are disinfected between clients with an EPA-registered disinfectant that is proven effective against HIV-1, or Hepatitis B, or is a Tuberculocidal.
	<input type="checkbox"/>	<input type="checkbox"/>	c. Clean linens are used for each client.
	<input type="checkbox"/>	<input type="checkbox"/>	d. Sheeting/pads that come in direct contact with the client or have been soiled are removed, disinfected, or cleaned between clients.
<b>6</b> <b><u>Storage:</u></b>	<input type="checkbox"/>	<input type="checkbox"/>	a. Flammable and combustible chemicals are stored away from potential sources of ignition such as an open flame or an electrical device.
	<input type="checkbox"/>	<input type="checkbox"/>	b. Cabinets, drawers, containers used for storage of tools, equipment, instruments and towels/linens are clean.
	<input type="checkbox"/>	<input type="checkbox"/>	c. Tools, equipment, instruments, or towels/linens which have been used on a client are not placed in a container with clean tools, equipment, instruments, or towels/linens.

	Met	Not Met	Inspection Areas
<b>7</b> <u>Towels/Linens:</u>	<b>Used Towel and Linen Storage:</b>		
	<input type="checkbox"/>	<input type="checkbox"/>	a. Cloth towels and linens are deposited in a closed receptacle after use.
	<input type="checkbox"/>	<input type="checkbox"/>	b. Used cloth towels and linens are not used again until properly laundered.
	<input type="checkbox"/>	<input type="checkbox"/>	c. Disposable towels are discarded in a covered waste receptacle immediately following each service.
	<b>Clean Towel and Linen Storage:</b>		
	<input type="checkbox"/>	<input type="checkbox"/>	a. All clean towels are stored in a clean, enclosed, dust-proof cabinet or container until used.
	<input type="checkbox"/>	<input type="checkbox"/>	b. Pillows are not required to be stored in a cabinet or container, but must have a clean covering before contact with a client.
<b>8</b> <u>Products:</u>	<input type="checkbox"/>	<input type="checkbox"/>	a. All liquids, creams, and other products are kept in clean, closed containers.
	<input type="checkbox"/>	<input type="checkbox"/>	b. Original product bottles and containers have an original manufacturer label, which discloses their contents.
	<input type="checkbox"/>	<input type="checkbox"/>	c. All products used on a client are dispensed by a spatula, scoop, spoon, squeeze bottle, pump, dropper, or similar dispenser so that the remaining product is not contaminated.
	<input type="checkbox"/>	<input type="checkbox"/>	d. If a product is poured into another container, such as a shaker, dispenser pump container, or spray container, the container is labeled to identify the product.
	<input type="checkbox"/>	<input type="checkbox"/>	e. Products applied to one client are removed and not reused on another client.
	<b>9</b> <u>Methods of Disinfection:</u>  <b>The owner must ensure that all electrical and/or mechanical tools, instruments, implements, and equipment are disinfected before use on a client, by using one of the following two procedures:</b>	<b>Procedure One:</b>	
<input type="checkbox"/>		<input type="checkbox"/>	a. Spray, immerse, soak, or saturate the implement until it is totally saturated with an EPA-registered disinfectant that is proven effective against HIV-1, or Hepatitis B, or is a Tuberculocidal.
<input type="checkbox"/>		<input type="checkbox"/>	b. Before removing the sanitized implement(s), wash hands with liquid soap and water or antibacterial solution.
<input type="checkbox"/>		<input type="checkbox"/>	c. Rinse implement.
<input type="checkbox"/>		<input type="checkbox"/>	d. Prior to storing, air-dry on a sanitary surface or dry with a clean sanitized towel.
<input type="checkbox"/>		<input type="checkbox"/>	e. Store in a clean enclosed cabinet or covered container reserved for clean implements until used.
<b>Procedure Two:</b>			
<input type="checkbox"/>		<input type="checkbox"/>	a. Autoclave implements in accordance with the manufacturers instructions.
<input type="checkbox"/>		<input type="checkbox"/>	b. Autoclaves are cleaned and serviced at the frequency recommended by the manufacturer.
<input type="checkbox"/>		<input type="checkbox"/>	c. Foot baths/foot spas, showers, and hot tubs are disinfected with an EPA registered disinfectant that is proven effective against HIV1, or Hepatitis B, or is a Tuberculocidal and in accordance with the manufacturers instructions.
<input type="checkbox"/>		<input type="checkbox"/>	d. Paraffin wax machines is clean. Paraffin wax removed from one client is not be re-melted and used by another client.

**Name of Disinfectant:** \_\_\_\_\_  
 (must say on the product container that it is proven against HIV-1 or Hepatitis B or is Tuberculocidal)

**EPA Registration #:** \_\_\_\_\_

	Met	Not Met	Inspection Areas
<b>10</b> <b><u>Activities Not Allowed:</u></b>	<input type="checkbox"/>	<input type="checkbox"/>	a. Smoking does not occur in the massage room.
	<input type="checkbox"/>	<input type="checkbox"/>	b. Licensees do not use, consume, serve, or in any manner possess or distribute intoxicating beverages or controlled substances upon its premises during the hours the establishment is open to the public.
<b>11</b> <b><u>Documents and Records:</u></b>	<input type="checkbox"/>	<input type="checkbox"/>	a. The license to operate the massage therapy establishment is displayed in a conspicuous location at the massage therapy establishment.
	<input type="checkbox"/>	<input type="checkbox"/>	b. There is a sign containing the name of the massage therapy establishment. The sign must be in a conspicuous location at the entrance to the massage therapy establishment.
	<input type="checkbox"/>	<input type="checkbox"/>	c. The license of each massage therapist who practices massage therapy in the massage therapy establishment is displayed in a conspicuous location at the massage therapy establishment.
	<input type="checkbox"/>	<input type="checkbox"/>	d. The establishment has one copy of the latest edition of the Massage Therapy Practice Act and one copy of the latest edition of 172 NAC 81 and 82.