



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Public Health – Licensure Unit
P.O. Box 94986, Lincoln, Nebraska 68509-4986
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Application for a Massage Therapy Establishment License or a Change in the License

Please Type or Print Clearly

It is your responsibility to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

SECTION A - GENERAL INFORMATION (All applicants must complete this section) **This section is public information and will be displayed on the INTERNET at <http://www.nebraska.gov/LISSearch/search.cgi>**

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:			

Additional information requested (This information is not displayed on the internet)

5	Address of the Owner of the Business	Street/PO/Route:		
		City:	State:	Zip:
6	If the applicant is a sole proprietorship, identify the social security number of the owner (this is REQUIRED INFORMATION . Neb. Rev. Stat. §38-123 mandates disclosure of your social security number to DHHS. Although your number is NOT public information, DHHS may disclose it for child support enforcement purposes and to the Nebraska Department of Revenue.			SS #:
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>Indicate the type of owner of this business:</p> <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Limited 1 liability company that has only one member <input type="checkbox"/> Limited liability company that has more than one member <input type="checkbox"/> Corporation <input type="checkbox"/> Governmental unit <input type="checkbox"/> Other: Identify Type _____			

For Office Use Only: Inspector Assigned: _____	For Office Use Only: License #: _____ Date Issued: _____
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All Licenses expire November 1, odd-numbered years (renewal fee will be \$127)

SECTION B – OPERATION INFORMATION (All applicants must complete this section)

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 - **but** must list days and times **most likely** 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 (All applicants must complete this section)

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

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

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

