NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Division of Public Health – Licensure Unit
P.O. Box 94986, Lincoln, Nebraska 68509-4986
402-471-2299
DHHS.RehabOffice@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 or other image of the layout of the establishment, including square footage and purpose for each area.
5. Complete the attached self-evaluation inspection report showing compliance with 172 NAC 82, section 004.

SECTION A: APPLICATION CATEGORY

☐ **NEW ESTABLISHMENT**

FEE: $127.00
$31.75 if your license is issued within 180 days of the expiration date (May-Oct odd-numbered yrs)

☐ **CHANGE IN OWNER AT SAME ADDRESS**

Previous Owner:	
Establishment Name:	
License #:	

FEE: $127.00
$31.75 if your license is issued within 180 days of the expiration date (May-Oct odd-numbered yrs)

☐ **CHANGE IN NAME OF ESTABLISHMENT (SAME OWNER)**

Previous Name:	
License #:	

FEE: $10.00

☐ **CHANGE IN LOCATION OF ESTABLISHMENT (SAME OWNER)**

Previous Address:	Street/PO/Route:		
	City:	State:	Zip:
Do you plan to close the previous location listed above:		Yes ☐ No ☐	
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)

All Licenses expire November 1, odd-numbered years (renewal fee will be $127)

SECTION B: GENERAL INFORMATION

1	Name of Establishment:			
2	Establishment Address:	Street/PO/Route:		
		City:	State:	Zip:
3	Telephone Number:	E-mail:	Website (optional):	

SECTION C: OWNER INFORMATION

Check the type of owner of this business:

☐ Sole Proprietorship (sole owner)	☐ Partnership
☐ Limited 1 liability company that has only one member	☐ Limited liability company that has **more than** one member
☐ Corporation	☐ Governmental Unit
☐ Oher: Identify Type:	

SOLE OWNER or PARTNERSHIP:

1	Full name of the Business Owner(s) or Partners:	Name:		Date of Birth:	
		Name:		Date of Birth:	
2	Home Address of the Business Owner(s):	Street/PO/Route:			
		City:	State:		Zip:
3	If the applicant is a **sole owner**, identify the social security number of the owner (this is **REQUIRED INFORMATION**) Social security numbers obtained under this section shall not be public information but may be shared by the department for administrative purposes if necessary and only under appropriate circumstances to ensure against any unauthorized access to such information.			SS #:	
4	Business Phone #:		Business Fax # (optional)	Owner E-Mail Address:	

CONVICTION INFORMATION: **If SOLE Owner or Partnership, you must list ALL** misdemeanor or felony convictions (regardless of when they occurred); you are NOT required to list infractions, diversions or dismissals. Misdemeanor and felony convictions can either be processed through traffic or criminal court, so when you check with the county court/district court, you should ask for both traffic and criminal court misdemeanor and felony convictions.

Have you **EVER** been convicted of a misdemeanor or felony?	Name of Conviction	Date of Action	Name of Court Taking Action
Yes ☐ No ☐			

The following provides SOME examples of convictions; this is NOT a complete list	
• MIP/ Tobacco Use by Minor • DUI / DWI • Controlled Substance • Open Container • Shoplifting / Theft / Burglary • Unauthorized use of a Financial Transaction • Disturbing the Peace • Assault / Prostitution • Disorderly Conduct / Disorderly House • Reckless Driving	• Driving under Suspension / Revocation • License Vehicle without Liability Insurance • Fail to Appear in Court • False Information or Reporting • Leave the Scene of an Accident • Operator not Carrying License • Unlawful Display of Plates/Renewal tabs • Park Rule Violation / Curfew Violation • Dog at Large / Fail to Vaccinate Animal • Littering / Fireworks / Bad Check

NOTE: If you have **any pending criminal charges that result in a conviction or license disciplinary actions** or license discipline, you are required to report such action to the Investigative Unit **within 30 days of the conviction or disciplinary action. Reporting forms can be obtained at the following website https://dhhs.ne.gov/Pages/Investigations.aspx** or by phone **402-471-0175**.

CORPORATION OR LIMITED LIABILITY COMPANY OR GOVERNMENT UNIT etc:

Complete the following information if the facility is owned by a corporation, limited liability or government unit, etc:

1	Name of Corporation, LLC, or Government Unit:			
2	Mailing address of the Business Owner(s) or corporate office. This should be an address **different from** the facility address:	Street/PO/Route:		
		City:	State:	Zip:
3	Federal Identification Number (FIN or EIN required)		FIN (EIN) #:	
4	Business Phone #:		Owner/Business E-Mail Address:	
5	Name of each Person in Control of the Business **MUST LIST ALL** (if space is not adequate, attach additional sheet)			

SECTION D: PROPERTY INFORMATION

Please include copies of the following documents on a separate page:

- Bill of Sale
  OR
- Lease Agreement and
- Landlord Information (Phone number, Email Address, First and Last Name, Landlord Business Name)

SECTION E: OPERATION INFORMATION

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

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

2. **You must list all persons in control of the business, include persons responsible for the day-to-day operations of the business.**

Name:	First:	Middle/MI:	Last:	Aliases:	
Address		City	State	Zip Code	
Phone Number:		Date of Birth	Driver's License/Gov't ID#		State Issued By
Email Address					
Name:	First:	Middle/MI:	Last:	Aliases:	
Address		City	State	Zip Code	
Phone Number:		Date of Birth	Driver's License/Gov't ID#		State Issued By
Email Address					

3. **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

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

SECTION F: Disciplinary Information
Please answer the following questions. If you answer "YES" to any of the questions, you must provide additional information.

Yes ☐ No ☐	Have you, or a company of which you were an owner, ever received a license or permit from any state/jurisdiction (including Nebraska) to own or operate a massage therapy establishment?

If yes, provide the following information (submit additional license information in an attached sheet):

Establishment Name	Establishment Address		
License Number	**Date Issued**	**Date Expired/Closed**	**State Issuing License**
Establishment Name	**Establishment Address**		
License Number	**Date Issued**	**Date Expired/Closed**	**State Issuing License**
Establishment Name	**Establishment Address**		
License Number	**Date Issued**	**Date Expired/Closed**	**State Issuing License**

Yes ☐ No ☐	Have you ever been employed at a massage therapy establishment that has had its license or application denied, surrendered, suspended, revoked or disciplined in any way?

If yes, on a separate page, provide the license number, state issuing license, date of action, and type of action (denial, probation, suspension, etc).

Yes ☐ No ☐	Have you ever been an owner of a massage therapy establishment that has had its license or application denied, surrendered, suspended, revoked or disciplined in any way?

If yes, on a separate page, provide the license number, state issuing license, date of action, and type of action (denial, probation, suspension, etc).

Yes ☐ No ☐	Have you previously owned, had an ownership interest in, or operated a massage therapy establishment or similar business in which the license or permit was denied, suspended, revoked or subjected to abatement proceedings?

If yes, on a separate page, provide the license number, state issuing license, date of action, and type of action (denial, probation, suspension, etc).

SECTION E: 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 F: 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, a corporation, a 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 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.

_____ Date _____
Signature of Owner/Representative as listed above

_____ Date _____
Signature of Owner/Representative as listed above

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LICENSURE UNIT
P.O. BOX 94986
LINCOLN, NEBRASKA 68509
(402) 471-2299 E-mail: DHHS.RehabOffice@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
		☐yes ☐no		☐yes ☐no
		☐yes ☐no		☐yes ☐no
		☐yes ☐no		☐yes ☐no
List the Name of Each Manager Responsible for Daily Operations				

Inspection:

	Met	Not Met	N/A	Inspection Areas
006.01 PHYSICAL STRUCTURE	☐	☐	☐	The physical structure must have a clearly identifiable location and can be free-standing or part of an existing structure. It must be well ventilated and kept in a clean, orderly, and sanitary condition at all times.
	☐	☐	☐	(A) All rooms must have adequate lighting and ventilation.
	☐	☐	☐	(B) A restroom must be available on the premises.
	☐	☐	☐	(C) There must be a supply of hot and cold running water.
	☐	☐	☐	(D) Doors, stairways, passageways, aisles, or other means of exit must provide safe and adequate access.
	☐	☐	☐	(E) There must be an area that can be screened from public view for clients requesting privacy.
	☐	☐	☐	(F) Each room where massage therapy services are provided must have an Environmental Protection Agency (EPA) registered disinfectant that is proven effective against HIV-1, or Hepatitis B, or is a Tuberculocidal, and have liquid soap and water or an instant sanitizer.
	☐	☐	☐	(G) If a massage therapy establishment is located within the massage therapy school, the room(s) utilized by the establishment licensee(s) must be clearly identified by the name of the establishment. If these same room(s) are utilized by the establishment for student clinics, the room(s) must be clearly identified as 'student clinic' while utilized by the students.
006.02 MASSAGE TABLES AND CHAIRS. All tables and chairs must be safe and in a sanitary condition at all times.	☐	☐	☐	(A) Tables and chairs must be disinfected between clients with an Environmental Protection Agency (EPA) registered disinfectant that is proven effective against HIV1, or Hepatitis B, or is a Tuberculocidal.
	☐	☐	☐	(B) Clean linens must be used for each client.
	☐	☐	☐	(C) Sheeting or pads that come in direct contact with the client or have been soiled must be removed and cleaned between clients.
006.03 STORAGE	☐	☐	☐	(A) Flammable and combustible chemicals must be stored away from potential sources of ignition such as an open flame or an electrical device.
	☐	☐	☐	(B) Cabinets, drawers, and containers used for storage of tools, equipment, implements, towels, and linens must be clean.
	☐	☐	☐	(C) Tools, equipment, instruments, or towels and linens which have been used on a client must not be placed in a container with clean tools, equipment, instruments, or towels and linens.
	☐	☐	☐	(D) All clean towels are stored in a clean, enclosed, dust-proof cabinet or container until used. Pillows are not required to be stored in a cabinet or container, but must have a clean covering before contact with a client.
006.04 TOWELS AND LINENS All towels and linens must be clean and sanitary for each client and meet the following requirements:	☐	☐	☐	(A) Cloth towels and linens must be deposited in a closed receptacle after use.
	☐	☐	☐	(B) Used cloth towels and linens must be not used again until properly laundered.
	☐	☐	☐	(C) Disposable towels must be discarded in a covered waste receptacle immediately following each service.

	Met	Not Met	N/A	Inspection Areas
006.05 PRODUCTS The requirements for products used at a school or establishment are as follows:	☐	☐	☐	(A) All liquids, creams, and other products must be kept in clean, closed containers.
	☐	☐	☐	(B) Original product bottles and containers must have an original manufacturer label, which discloses their contents.
	☐	☐	☐	(C) All products used on a client must be dispensed by a spatula, scoop, spoon, squeeze bottle, pump, dropper or similar dispenser so that the remaining product is not contaminated.
	☐	☐	☐	(D) If a product is poured into another container, such as a shaker, dispenser pump container, or spray container, the container must be labeled to identify the product
	☐	☐	☐	(E) Products applied to one client cannot be removed and reused on another client.
006.06 METHODS OF DISINFECTION All electrical and mechanical tools, instruments, and implements must be disinfected before use on a client, using one of the following procedures:	☐	☐	☐	(A) Spray, immerse, soak, or saturate the implement until it is totally saturated with an Environmental Protection Agency (EPA) registered disinfectant that is proven effective against HIV-1, or Hepatitis B, or is a Tuberculocidal. (i) Before removing the sanitized implement, wash hands with liquid soap and water or antibacterial solution. (ii) Rinse implement. (iii) Prior to storing, air-dry on a sanitary surface or dry with a clean sanitized towel. (iv) Store in a clean enclosed cabinet or covered container reserved for clean implements.
	☐	☐	☐	(B) Autoclave implements in accordance with the manufacturer's instructions. Autoclaves must be cleaned and serviced at the frequency recommended by the manufacturer.
	Name of Disinfectant: _____ (must say on the product container that it is proven against HIV-1 or Hepatitis B or is Tuberculocidal) **EPA Registration #:** _____			
006.07 FOOT BATHS, FOOT SPAS, SHOWERS, AND HOT TUBS	☐	☐	☐	All foot baths, foot spas, showers, and hot tubs must be disinfected with an Environmental Protection Agency (EPA) registered disinfectant that is proven effective against HIV-1, or Hepatitis B, or is a Tuberculocidal and in accordance with manufacturer's instructions.
006.08 PARAFFIN WAX MACHINES	☐	☐	☐	Each paraffin wax machine must be kept clean, the paraffin wax must be removed for each client, and wax cannot be re-melted and used by another client.
006.09 PROHIBITED ACTIVITIES	☐	☐	☐	The following activities are prohibited: (A) Smoking or vaping; and (B) Consuming, serving, or in any manner possessing intoxicating beverages upon the premises during the hours the establishment and school is open to the public.

	Met	Not Met	N/A	Inspection Areas
006.10 DOCUMENTS AND RECORDS The following must be posted or available in establishments and schools:		006.10(A) POSTED.		
	☐	☐	☐	Copies of the following documents must be posted for public viewing: (i) The current establishment and school license.
	☐	☐	☐	(ii) A sign containing the name of the establishment and school. The sign must be located at the entrance to the establishment and school.
	☐	☐	☐	(iii) The current license of each massage therapist who practices massage therapy in the establishment.
	☐	☐	☐	(iv) The current license of each massage therapist who teaches massage therapy in the school. (v) The current license of the regularly licensed physician.
		006.10(B) AVAILABLE.		
	☐	☐	☐	At least 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 must be available.
If you selected N/A for any of the inspection items, please provide an explanation:				

Establishment Signature (Must be signed by the Owner(s)):

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

Signature _____ Date _____