



CITY AND COUNTY OF SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
ENVIRONMENTAL HEALTH BRANCH, 49 SOUTH VAN NESS AVE, SUITE 600, 94103
**APPLICATION FOR PERMIT TO OPERATE A MASSAGE
ESTABLISHMENT**

Date of Application:

Type of Establishment: <input type="checkbox"/> General Massage <input type="checkbox"/> Sole Practitioner		<input type="checkbox"/> OutCall Service	FACILITY ID NO.	
TRADENAME (DBA): ADDRESS:		<input type="checkbox"/> Sole Owner <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation	<input type="checkbox"/> New Installation <input type="checkbox"/> Ownership Change <input type="checkbox"/> Reclassification <input type="checkbox"/> Record Purpose	Remodel? <input type="checkbox"/> Yes <input type="checkbox"/> No
CROSS STREET:	EMAIL ADDRESS:	BUSINESS PHONE NO.	CELL PHONE NO.	
Name of: a) Person to whom permit will be issued, or b) Corporation name and names of principal Officers and stockholders with more than or equal to 10% ownership (include percentage of each listed individual)		Home Address of: a) each applicant with birth date, or b) each practitioner for Solo Practitioner Establishment, or c) Corporation and Corporate Officers		
		Contact Person:		
Emergency name & phone:		Home Telephone:		
Has any applicant, including corporate officers and stockholders, EVER BEEN CONVICTED OF ANY FELONY OR MISDEMEANOR <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please attach a list of each conviction along with the date of the conviction.</i>				
Are you currently pending any investigation regarding any felonies, misdemeanors or lewd conduct <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please attach a list of each conviction along with the date of the conviction.</i>		Have you ever had any massage license or massage establishment licenses denied, suspended or revoked: <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please attach information about the license denial, revocation or suspension, including dates.</i>		
ATTACH: 1) WRITTEN OPERATIONAL PROCEDURES WHICH DESCRIBE THE EXACT NATURE OF THE SERVICES TO BE PROVIDED 2) PRACTITIONER LIST (FOR MASSAGE ESTABLISHMENTS). PROVIDE COPY OF CURRENT SF MASSAGE PRACTITIONER LICENSE OR CALIFORNIA MASSAGE THERAPY COUNCIL(CAMTC) CERTIFICATE. 3) LIST OF PREVIOUS MASSAGE PERMITS OR LICENSES HELD				

I declare under penalty of perjury the information on this application and in other materials submitted in support of this application are true and correct. I hereby consent to all necessary inspections made pursuant to the Massage Ordinance and incidental to the issuance of any exemption, Registration or Permit, and operation of this business. I have checked with the Planning Department prior to submitting this application to verify that this location is zoned for a Massage Establishment. **I understand that once submitted, the application fee is nonrefundable.**

***SIGNATURE(S) OF APPLICANT(S)**

X _____	X _____
X _____	X _____

**If Partnership, all partners must sign. If Corporation, authorized Officer must sign. Attach extra sheets if necessary.*

FOR OFFICE USE ONLY

Filing Fee & Receipt # _____	Zoning Referral _____	Lease Agreement _____	Previous Permits _____
Out of Business Notification _____	Labor & Workers' Comp _____	Practitioner list _____	Home Addresses _____
		Owner(s) Background Check _____	Corporate Address _____

INSPECTOR'S REPORT

To the Director of Public Health:

After having made a careful inspection in the above case on _____ 20

I RECOMMEND the issuance of a New Permit to operate ☐
I DISAPPROVE the issuance of a New Permit to operate ☐ for the following reasons:

PRINCIPAL INSPECTOR		INSPECTOR			
HEARING DATE	APPROVED Y <input type="checkbox"/> N <input type="checkbox"/>	DISTRICT NO.	CENSUS TRACT	PERMIT NO.	TYPE OF PERMIT / CLASSIFICATION