St. Joseph County Department of Health

"To promote health and wellness with compassion and integrity through partnerships, education, protection, and advocacy for all who reside in and visit St. Joseph County."

ST. JOSEPH COUNTY DEPARTMENT OF HEALTH
Prevent. Promote. Protect.

APPLICATION FOR NEW: MASSAGE THERAPIST LICENSE

1. Name of Applicant: _____
2. Local Home Address, City and Zip: _____
3. Local Phone #: _____ Mobile #: _____
4. Date of Birth: _____ E-Mail Address: _____
5. Name and Address of Establishment(s), if any, at which you are or expect to be employed:

_____ _____ _____ _____

_____ _____ _____ _____
Address City State Zip

6. Further requirements for completion of this application:

a. Provide a copy of a current Massage Therapist License from the Indiana State Board of Massage Therapy (ISBMT).

b. Provide a copy of your diploma and transcript from a recognized School of Massage Therapy.

c. Provide a current valid driver's license or government-issued identification.

d. Provide a non-refundable fee of one hundred dollars **($100.00)** payable every February.

e. Must **INCLUDE** a self-addressed stamped envelope to obtain the license.

f. Have you ever had a Massage Permit or License suspended or revoked? Yes ____ No ____

If yes, explain the reason(s): _____

_____

No Personal Checks Accepted. We will accept Money orders, Cashier's checks, Business checks, Visa, MasterCard or Discover. Please Note: We are not able to process credit card transactions by phone or by mail.

I certify that the information provided above is true and accurate. I understand that failure to provide true and accurate information or a violation of County Code 113 may result in the cancellation of my license and assignment of financial penalties of up to $1,500 per violation, per day. I certify that I will not perform massage therapy in a residence or an establishment that does not possess a Massage Establishment License (certain exceptions apply, such as medical facilities).

Signature: _____ Date: _____

FOR OFFICE USE ONLY!

EHS Determination: _____ Approved / Disapproved: Date: _____

Date Paid: _____ Transaction #: _____ SR/License #: _____ Staff Initials: _____

Please send all electronic correspondence for the Environmental Health Unit to envirohd@sjcindiana.com

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