



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."

Revised 2025

Page 1

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. **List the names and addresses of all establishment(s), where you are or expect to be employed:**
Name: _____ Address (City, State, Zip): _____
Name: _____ Address (City, State, Zip): _____
Name: _____ Address (City, State, Zip): _____
6. **Has the applicant ever had a massage therapist or establishment permit/license suspended or revoked?** Yes ___ No ___
If yes, explain the reason(s): _____
7. **List the last two most recent previous residential addresses:**
Address (City, State, Zip): _____
Address (City, State, Zip): _____
8. **List all previous employment for the last two years:**
Name: _____ Address (City, State, Zip): _____
Name: _____ Address (City, State, Zip): _____
Name: _____ Address (City, State, Zip): _____
9. Provide a copy of a current Massage Therapist License from the Indiana State Board of Massage Therapy.
10. Provide a current, valid driver's license or government-issued identification.
11. Provide a copy of your diploma and transcript from a recognized School of Massage Therapy.
12. A fee of one hundred ten dollars (\$110.00) is to accompany this annual application, due every February.
13. Your license(s) will be distributed during the inspection of the establishment.

No Personal Checks Accepted. We accept Money orders, cashier's checks, Business checks, and major credit cards (Visa, MasterCard, or Discover). Please note that we are unable to process credit card transactions by phone or mail. Once fees have been paid, they are non-refundable and non-transferable. We are not responsible for lost or undelivered 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 #: _____ Total Fee: _____

SR/License: _____ Employee: _____