EAST SHORE HEALTH DISTRICT
688 East Main Street, Branford, CT 06405 (203) 481-4233

FOR OFFICE USE ONLY:
Date: _____ Fee: _____ Payment Type: _____ Receipt #: _____ Paid by:_____

PERMIT APPLICATION TO OPERATE A MASSAGE ESTABLISHMENT

Date:_____

Business Name: _____ Phone: ( )_____

Business Address: _____ Town:_____ Zip _____

Mailing Address: _____ Town:_____ Zip _____

Email _____

Type of Ownership (Mark one): ☐ Individual ☐ Partnership ☐ Corporation ☐ Workstation renter ☐ Other

If individual ownership, list owner below, if partnership, list all partners, if corporation, list corporation name and all officers:

Owner/Renter's Name:_____ Phone_____

Home Address:_____ Town:_____ Zip:_____

Owner/Renter's Name:_____ Phone_____

Home Address:_____ Town:_____ Zip:_____

MASSAGE PERMIT	**FEE**
1 table/workstation 2-4 tables/workstations >5 tables/workstations	**$125.00** **$150.00** **$175.00**
Re-Inspection Fee 2nd Reinspection Fee	**$75.00** **$125.00**
Renewal Permit Application Late Fee	**$15.00/day**
Returned Check Fee	**$20.00**
Plan Review Fee	**$125.00**

I attest that the information supplied here is accurate and correct. I understand that this permit may not be issued or, after issuance, may be suspended, revoked, or not renewed for noncompliance with the *East Shore Health District's Regulations Pertaining to Massage Therapy Establishments code* and/or the *Connecticut Public Health Code.*

_____ _____ _____
Signature & Title **Type or Print Name** **Date**

OWNER OF ESTABLISHMENT: Total number of Workstations:_____

Number of LMT employed:_____

Do you rent out work space?_____If yes, how many stations are rented?_____

RENTER: Number of workstations you are renting: _____

Hours & Days of Operation:_____

List all chemicals and sanitizing/disinfection devices used:_____

_____

Check all procedures performed on premises:

- ☐ Facial or scalp massage
- ☐ Massaging, cleansing, exercising, stimulating, or manipulating, with the hands or mechanical appliances, the head, scalp, face, neck, arms, hands, body, legs, or feet
- ☐ Application of cosmetics, oils, creams, antiseptics, tonics, powders, clays, lotions, or other preparations, either by hand or mechanical appliance, to the head, scalp, face, neck, arms, hands, body, legs, or feet
- ☐ Other:_____

_____

Water Supply: ☐ Public (RWA) ☐ On-Site Well **Sewage Disposal:** ☐ City ☐ Septic system

For all **new establishments, **establishments undergoing renovation or with new owners**, the following departments must sign this application prior to permitting your establishment:

Zoning Department: _____ _____
Signature Date

Building Department: _____ _____
Signature Date

Fire Department: _____ _____
Signature Date

Police Department: _____ _____
Signature Date

EAST SHORE HEALTH DISTRICT: _____ _____
Signature Date