Governed by Chapter 114

YEAR______________

NEW____ or RENEWAL____

TOWNSHIP OF WAYNE

CLERK'S OFFICE
475 VALLEY ROAD
WAYNE, NJ 07470

APPLICATION – MASSAGE, BODYWORK AND SOMATIC THERAPY ESTABLISHMENT LICENSE

TO AVOID A DELAY IN THE ISSUANCE OF YOUR LICENSE, PLEASE COMPLETE APPLICATION IN ITS ENTIRETY
(Please make checks payable to Township of Wayne & submit with application to the Township Clerk's Office)

Applicant Please Check One:

________CORPORATION, ________PARTNERSHIP, __________LLC, or _________SOLE PROPRIETORSHIP

IF APPLICANT IS INCORPORATED: DATE:______________ WHAT STATE:______________

ATTACH: CERTIFICATE OF INCORPORATION WITH LIST OF OFFICERS, IF INCORPORATED

NAME CORP/PARTNER/LLC/SOLE PROP.:____

ADDRESS:____

TRADE NAME:____

ADDRESS OF ESTABLISHMENT:____

____

OFFICE TEL#________________________ **CELL#**_______________________ **FAX#**__________________________

EMAIL ADDRESS:____

1. **TAXPAYER ID (Federal Employer ID Number):** Your Taxpayer Identification (FEIN) must be twelve digits long:
   1.____
2. **BUSINESS ENTITY ID:** This is the ten-digit ID assigned to all corporations, LLC's and limited partnerships. If your business is a General Partnership or Proprietorship, this search field is not applicable:
   2.____

LIST NAME, ADDRESS. & PHONE NO. OF EACH PARTNER/OFFICER (AS APPLICABLE) AND MANAGER(S)

***** *LIST PRIMARY/APPLICANT CONTACT NAME FIRST* *****

	LAST NAME, FIRST NAME	HOME ADDRESS	HOME PHONE NO.
1.			
2.			
3.			
4.			
5.			

LICENSE FEE: (Non-Refundable) **$500.00** **LATE FEE: $25.00** (If payment is made after JUNE 30TH) **EXP. JUNE 30TH** of each year

FOR OFFICE USE ONLY:

FEE PAID:_________ DATE:___________ CHECK NO._________ CASH_______

NEW APPLICATIONS (Only):Plng___Bd___ Hlth___ Fire___ R&I___ Revenue ___ COUNCIL MTG.__________

***For Renewal Applications only*:**

R&I_____ Health_______ Fire_____ COUNCIL MTG.____________

TWO (2) PRIOR ADDRESSES FOR EACH PARTNER/OFFICER (AS APPLICABLE) AND MANAGER(S)

LAST NAME, FIRST NAME **COMPLETE HOME ADDRESS**

1.(ADDRESS):____

2.(ADDRESS):____

1.(ADDRESS):____

2.(ADDRESS):____

1.(ADDRESS):____

2.(ADDRESS):____

1.(ADDRESS):____

2.(ADDRESS):____

1.(ADDRESS):____

2.(ADDRESS):____

1.(ADDRESS):____

2.(ADDRESS):____

EXPERIENCE INFORMATION

The sole proprietor/partner(s)/officer(s) (as applicable) and manager(s) named in this application must give a brief summary of massage therapy or similar business history and experience. Each person shall complete their own ***Addendum Page (attached)***.

Does Applicant OWN_______or LEASE________ property *(establishment location)?*

If property is leased, is Applicant responsible for WATER/SEWER payments with the Township? Yes ____ or No____

LEASOR/PROPERTY OWNER INFORMATION

NAME:____

HOME ADDRESS:____

DAYTIME TEL #:_________________________________ **EMAIL**_________________________________

1. Have any of the persons named in this application previously operated in this or another municipality or state under a license or permit or has had such license or permit denied, revoked or suspended and the reason therefore and the business activities or occupations subsequent to such action or denial, suspension or revocation: YES ____ NO ____

(If answer is YES, please list each person it applies to and explain in detail below)

LAST NAME, FIRST NAME

1. ____
____
____
2. ____
____
____
3. ____
____
____

2. Have any of the persons named in this application ever been convicted of any criminal offense other than a misdemeanor traffic violation. YES _____ NO _____

(If answer is YES, please list each person it applies to and explain in detail below. You must fully disclose the jurisdiction in which convicted and the offense for which convicted and circumstances thereof:

LAST NAME, FIRST NAME

1. ____
____
____
2. ____
____
____
3. ____
____
____

BY SIGNING THIS APPLICATION, I AFFIRM THAT I HAVE READ AND UNDERSTAND ALL THE PROVISIONS OF THE CODE OF THE TOWNSHIP OF WAYNE WITH RESPECT TO MY LICENSE/PERMIT.

____
Applicant Signature **Date**

____
Print Name

THIS FORM MUST BE NOTARIZED

Sworn and subscribed before me this

__________ day of ___________________, 20_______

____
Notary Public

TRADE NAME____

ADDRESS (Massage Establishment):____

NAMES OF ALL MASSAGE THERAPISTS & EMPLOYEES

NAME (EMPLOYEE)	JOB TITLE	RESIDENCE ADDRESS	HOME PHONE NUMBER	CELL PHONE NUMBER	State Massage Therapy License YES or NO
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

PLEASE NOTE: It shall be the responsibility of the owner/operator to maintain an updated employee list and provide same to the Township Clerk's Office. The Township Clerk shall be notified in writing within seven (7) days, transmitted by regular mail, email or facsimile, of any and all changes to the list. This list shall also be made available during all inspections

THIS IS TO CERTIFY THAT I, ____________________________, THE APPLICANT, CERTIFY THAT THE NAME(S) LISTED AS MY EMPLOYEES ARE CERTIFIED BY THE STATE OF NEW JERSEY PURSUANT TO THE MASSAGE, BODYWORK AND SOMATIC THRAPIST CERTIFICATION ACT, N.J.S.A. 45:11-53, ET SEQ.

DATE:______________________________

OWNER'S SIGNATURE ________________________________

PRINT NAME________________________________

HOME ADDRESS________________________________

____

THIS FORM MUST BE NOTARIZED

Sworn and subscribed before me this

__________ day of ___________________, 20_______

____

Notary Public

ADDENDUM PAGE *for:*

- ***Sole proprietor/partner(s)/officer(s)*** *(as applicable)*
- ***Manager(s)***

PLEASE MAKE AS MANY COPIES OF THIS PAGE AS NEEDED

Name of Massage Establishment:____

Name of person:____
LAST NAME *FIRST NAME*

SUMMARY OF MASSAGE THERAPY OR SIMILAR BUSINESS HISTORY AND EXPERIENCE: