



# PLAINVILLE-SOUTHINGTON REGIONAL HEALTH DISTRICT

Main Office  
196 NORTH MAIN STREET  
SOUTHINGTON, CT 06489

Satellite Office  
ONE CENTRAL SQUARE  
PLAINVILLE, CT 06062

860-276-6275 • FAX 860-276-6277 • pshd.org  
SHANE LOCKWOOD, M.P.H., R.S., DIRECTOR OF HEALTH



## MASSAGE LICENSE APPLICATION (Therapy, Therapist or Technician)

Annual License Fee: \$100

Date: \_\_\_\_\_ Type of Business: \_\_\_\_\_  
(Massage Only / Fitness / Spa / Physical Therapy)

Business Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Owner's Name(s)/ Address/ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Property Owner's Name/ Address/ Phone (if different): \_\_\_\_\_

Hours and Days of Operation: \_\_\_\_\_

# of Massage Tables/Chairs: \_\_\_\_\_ Is there a sauna or steam room?: \_\_\_\_\_

Are showers provided?: \_\_\_\_\_ If yes, how many: Men's: \_\_\_\_\_ Women's: \_\_\_\_\_ Unisex: \_\_\_\_\_

Do you provide towels, linens or sheets?: \_\_\_\_\_. If yes, please explain where and how they are laundered:

Names and License #'s of all massage therapists/technicians: \_\_\_\_\_

*Attach copies of all licenses to this form.*

To the best of my knowledge and understanding, the information I provided above is true and accurate.  
I agree to comply with any state or local laws, regulations or ordinances regarding this facility and operation.

\_\_\_\_\_  
Print Name Signature Date

\*\*\*\*\*Health District Only\*\*\*\*\*

Date Paid: \_\_\_\_\_ Amount Paid: \_\_\_\_\_