



Town of Greenwich
Department of Health
Division of Environmental Services
(203) 622 – 7838
www.greenwichct.org

<input type="checkbox"/> New Facility
<input type="checkbox"/> Change of Ownership
<input type="checkbox"/> License Renewal
<input type="checkbox"/> Remodeling
License Filing Fee: _____
Fees are non-refundable

Application to Operate a Body Care /Massage* Facility

INFORMATION REQUESTED ON THIS APPLICATION MUST BE COMPLETE OR APPLICATION WILL BE RETURNED. All services offered must also be listed. Any service added after a license is issued must be brought to the attention of the Department in writing prior to adding the service. At the time of filing this application, authorization will be given to verify employee information. Licenses are non-transferable.

*ADDITIONAL FACILITY LICENSE IS REQUIRED FOR MASSAGE ESTABLISHMENTS

Checklist for Massage Applicants: Make sure all items have been completed and/or included

- Completed Application (Sections 1, 3, and 4. Complete Section 2 if this is an initial application). Provide ALL information requested.
- Sign Application on Page 2 and Page 4.
- Include State of CT Resale Tax ID# on application OR include a separate letter addressed to Michael Long stating that no services or items are sold which require a Resale Tax ID#
- Photo ID for Applicant (Person who signs application)
- Photo ID for licensed massage therapist(s)
- Copy of massage therapist(s) State of CT Massage Therapy License(s)
- License Fee: Payable to the Town of Greenwich

SECTION 1: To Be Completed By All Applicants

Name of Facility: _____

Address: _____ City _____ State _____ Zip _____

Telephone: _____ Fax: _____ Days/Hours of Operation: _____

Name of Owner (Applicant): _____

Home Address: _____ City _____ State _____ Zip _____

Home Telephone: _____

Person Responsible (if other than owner): _____

Home Address: _____ City _____ State _____ Zip _____

Home Telephone: _____

Is Ownership: Sole Proprietor _____ Corporation _____ Limited Liability Corporation(LLC) _____ Other _____

Name of Corporation _____ Address/City/St _____

Corporations must attach a list of all current directors and officers. The Department must be notified in writing when there is a corporation change of officers and directors.

Water Supply (Check One):

- Public Supply
- Private Well

Sewage Disposal (Check One):

- Town Sewer
- Septic System

Business Type (Check All That Apply)

- Barber Shop
- Beauty / Hair Salon
- Fitness Center
- Hair Removal
- Massage Establishment*

- Nail Salon
- Skin Care/Treatment Facility
- Tanning Salon
- Tattoo/Body Piercing Salon
- Other: _____

Services Offered (Check All That Apply)

- Hairdressing and Barbering
- Manicuring
- Pedicure
- Artificial Nails
- Body Wraps
- Hot Stone Therapy
- Tattooing

- Skin Care/Treatment
- Ear/Body Piercing
- Hair Removal
- Waxing
- Massage
- List Types: _____
- Tanning
- Other (Describe All) _____

Number (Quantity) of Licensed/Certified Professionals**:

- | | | |
|--|--|---|
| <input type="checkbox"/> Barbers | <input type="checkbox"/> Massage Therapists | <input type="checkbox"/> Tattoo Technicians |
| <input type="checkbox"/> Hairdresser/Cosmeticians | <input type="checkbox"/> Physicians (MD) | <input type="checkbox"/> Physicians Assistant |
| <input type="checkbox"/> Nail Technician | <input type="checkbox"/> Hypertrichologists | <input type="checkbox"/> Registered Nurses (RN) |
| <input type="checkbox"/> Body Piercing Technicians | <input type="checkbox"/> Advanced Practice Registered Nurse (APRN) | <input type="checkbox"/> Other |

****ATTACH COPIES OF CURRENT STATE OF CONNECTICUT LICENSES AND TRAINING
CERTIFICATION DOCUMENTS**

Number (Quantity) of Workstations/Treatment Rooms and other related items within the Facility:

- Workstations (for hairdressing, barbering, cosmetology, body piercing, tattooing etc.): _____
- Shampoo Sinks: _____ Massage Rooms: _____ Manicuring Stations: _____ Pedicure Chairs: _____
- Saunas: _____ Storage Rooms: _____ Skin Care/Treatment Rooms: _____ Bathrooms: _____ Showers: _____
- Whirlpools: _____ Medical Storage Rooms: _____

In signing this application, I have agreed to abide by and provide the required information as outlined in Article 7 of the Town of Greenwich Body Care Facilities Ordinance. In addition, I will adhere to all other applicable state and local regulations.

Name of Licensee (Applicant): _____ Title: _____
 Signature of Licensee _____ Date: _____
 Please Print (where applicable)

SECTION 2: To be completed for Initial Licensing Only

For all services listed, supply the following information for initial licensing.

- ❑ List **all** Facility employees with home address, contact phone number, copies of all current State of Connecticut licenses, certificates and documentation of training (certification) for each. (Note: documents of training must include what procedures professionals have been trained in and all non-licensed/certified personnel must also be listed with job assignments).
- ❑ Medical history of all communicable diseases and a current state of health for all employees who provide skin care/treatment, massage, manicure/pedicure, and body piercing/tattooing services.
- ❑ Submit copies of Building and Fire Marshall approval (where applicable)
- ❑ Submit Consumer Protection and State of Connecticut approval and/or licensure (where applicable)

SECTION 3: To be completed for Massage License Only

Massage Applicants Must Provide The Following Additional Information and Submit a Copy of Photo ID with Proof of Age:

Date of Birth: _____ Social Security Number: _____
(Applicant must be at least 18 years of age)

State of CT Resale Tax ID Number (if applicable): _____. If not applicable then letter of advisement must be submitted with this application. See sample letter in Massage Packet.

BUSINESS/OCCUPATION OR EMPLOYMENT HISTORY

Name of Business or Occupation:	Address:	Dates:
Description of Services or Duties:		
Name of Business or Occupation:	Address:	Dates:
Description of Services or Duties:		
Name of Business or Occupation:	Address:	Dates:
Description of Services or Duties:		

Have you previously operated a Massage Establishment in Connecticut or any other state? YES () NO ()
 If YES, list Name, Address, and Dates of Operation: _____

Has your license ever been Denied, Suspended, or Revoked? YES () NO ()
 If YES, Why? _____

Have you ever been convicted of any offenses other than motor vehicle violations within the past ten years? YES () NO (). If YES, state the place and date of conviction, the nature of the offense and any further explanation. _____

Names and addresses of persons with financial interest in Massage Establishment and amount of interest (corporate applicants provide information for corporate officers with 10% or more interest).

Name	Home Address / City / State / Zip	%Interest

(Attach additional information on separate sheet)

List Massage Therapists: Provide Photo ID and copy of State of CT Massage Therapist License

Name	Home Address / City / State / Zip	License No.

(Attach additional information on separate sheet)

List Other Employees:

Name	Home Address / City / State / Zip	Job Title/Description

(Attach additional information on separate sheet)

SECTION 4: To be completed for Massage License Only

I authorize and release to the Director and to the Greenwich Police Department to seek information or references necessary to verify the information contained in the application.

Applicant's Signature _____ Date: _____

Town of Greenwich Approvals:

Police Department _____ Date: _____
Approval

Health Department _____ Date: _____
Approval

The Following Approvals as Necessary:

() Planning and Zoning _____ Date: _____
Approval

() Building Department _____ Date: _____
Approval

() Fire Department _____ Date: _____
Approval

Office Use Only

Date Application Received: _____
 Date Application Forwarded to Police Department _____ Returned: _____
 Date Application Forwarded to: _____ Returned: _____
 Date Application Forwarded to: _____ Returned: _____