



### MESSAGE THERAPIST PERMIT APPLICATION FORM

Environmental Public Health Division  
515 S. Liberty Street  
P. O. Box 1019  
Independence, MO 64051-0519  
Phone: (816) 325-7803 Fax: (816) 325-7074  
www.independencemo.org/health

Picture identification is required to process application (i.e. driver's license, passport, etc.) PLEASE PRINT LEGIBLY.

Name: ( First, Middle, Last, Suffix, Former/Maiden)

Social Security # \_\_\_\_\_

Date of Birth : \_\_\_\_\_

Address: (for last 3 years)

State Certificate #: \_\_\_\_\_

Gender: \_\_\_\_\_

Phone #: \_\_\_\_\_

#### EMPLOYMENT RECORD

Current Place of Employment:

Name: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

#### PROFESSIONAL EXPERIENCE -List all employers in the past three years that were massage establishments

Former Place of Employment

Name: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

Employment Date: \_\_\_\_\_ to \_\_\_\_\_

Business Type: \_\_\_\_\_

Position: \_\_\_\_\_

Phone #: \_\_\_\_\_

Former Place of Employment:

Name: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

Employment Date: \_\_\_\_\_ to \_\_\_\_\_

Business Type: \_\_\_\_\_

Position: \_\_\_\_\_

Phone #: \_\_\_\_\_

Did you graduate from a school of massage?  Yes  No If yes list the name and address of school(s) and attendance dates

What massages are you certified in? How Many Hours?

Have you had any other courses of study or practical experience, other than that listed, which would qualify you as a massage therapist?  Yes  No If yes, describe

Have you ever been licensed as a Massage Therapist?  Yes  No If yes, who issued such a license?

Have you ever had any license to perform as a massage therapist, etc., denied or revoked?  Yes  No If yes, what were the circumstances of such denial or revocation?

Have you ever been convicted of any law violations, other than minor traffic violations?  Yes  No If yes, list offense(s) and date(s):

I certify that the answers I have made to each and all of the questions in the application are full and true to the best of my knowledge and belief.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Office Use Only:

\_\_\_\_ Copy of National Certification or letter of sponsorship from a licensed physician, chiropractor, physical therapist, or massage therapist.

\_\_\_\_ Copy(s) of any massage therapy graduation certificate

\_\_\_\_ Copy of State certification

\_\_\_\_ Copy of Certificate of Health

Not Approved

Approved

Date \_\_\_\_\_