MASSAGE ESTABLISHMENT APPLICATION

Community Development Department-Health Permit Division
111 E Maple St
P. O. Box 1019
Independence, MO 64051-0519
Phone: (816) 325-7803 Fax: (816) 325-7770
www.independencemo.org

This form must be completed for all new and change of ownership facilities and for any changes to facility information. **If the information on this application changes, this department is to be notified.** **Picture identification is required to process application (i.e. driver's license, passport, etc.)** PLEASE PRINT LEGIBLY.

Facility Name: (as it will be shown on permit)	Phone: ( )_____ Fax: ( )_____ Cell: ( )_____ Email: _____ Website: _____
Facility Address:	
Anticipated Opening Date:	Ownership Legal Type: ☐ LLC ☐ Corporation ☐ Individual ☐ Partnership Date of Incorporation or Partnership _____ Location: _____

OWNERSHIP INFORMATION

Owner's Name:		Phone: ( )_____ Cell: ( )_____ Fax: ( )_____ Email: _____ Website: _____
Owner's Address:_____ City, State:_____ Zip:_____	Date of Birth:_____ SS#: _____ DL #: _____	

CO-OWNER/PARTNER INFORMATION

Owner's Name:		Phone: ( )_____ Cell: ( )_____ Fax: ( )_____ Email: _____
Owner's Address:_____ City, State:_____ Zip:_____	Date of Birth:_____ SS#: _____ DL #: _____	

EMPLOYEE INFORMATION

Names of managing officers, employees:

Name	Address	Date of Birth

A HEALTH CERTIFICE ISSUED BY A LICENSED MEDICAL PRACTITONER IS REQUIRED FOR EACH EMPLOYEE LISTED (use back of form if needed)

For Office use only: Date: _____ ☐ Approved ☐ Not Approved Permit# _____

Signature _____ Title _____

Printed Name _____ Date _____