

**APPLICATION FOR LICENSE
MASSAGE THERAPIST
City Of Quincy**

Name of applicant (Print) _____
(first) (initial) (last)

Date of Birth ____/____/____ Social Security # _____

Height: _____ Weight _____ Hair Color _____ Eye Color _____

Home address _____ Phone # _____
(street) (city) (state) (zip)

Name of Business _____ FEIN _____
(Federal Employer Identification Number)

Business address _____ Phone # _____
(street) (city) (state) (zip)

Name of Current Employer _____

Address of Current Employer _____

Length of Employment _____ Date of last application for this license _____

Period of time for current application _____

Do you possess a valid Illinois Massage Therapist license? Yes No

Do you possess a valid Massage Therapist license from another state? Yes No State _____

Do you possess a valid Bodywork certificate? Yes No Organization _____

Attach copy of current State License or Bodywork Certificate.

Signature _____ Date _____

OFFICE USE BELOW

Background Attached Photo Attached State License Attached \$25 fee Accepted

Approved _____ Disapproved _____ Date _____

City Clerk _____ Date _____

**MASSAGE THERAPIST
BACKGROUND QUESTIONNAIRE
City Of Quincy**

List all other Residences in Past Three Years

List Names and Addresses of all other Employers in Past Three Years

Has your Massage Therapy license been suspended or revoked in any state? Yes No

If "yes" Explain _____

Have you ever been convicted of a Felony in this or any other jurisdiction? Yes No

If "yes" Explain _____

Have you ever been convicted for violating any provisions of Chapter 130: Massage Therapists of the Code of the City of Quincy or any similar law in this or any other jurisdiction? Yes No

If "yes" Explain _____

I, the above listed applicant, authorize the Chief of Police, or designee, to conduct an investigation into my background. I attest that the information in this application and background questionnaire is complete and truthful and acknowledge that any false information may be grounds for refusal or revocation of my Massage Therapist license.

Signature _____ Date _____

OFFICE USE BELOW

Results of Background Pass Fail Date _____ *Attach Photo*

Official Completing Background Check _____

Signature _____ Date _____

Remarks
