Massage Establishment Change of Location/ Name Application

Florida Board of Massage Therapy
PO Box 6330
Tallahassee, FL 32314-6330

Web: www.floridasmassagetherapy.gov
Email: info@floridasmassagetherapy.gov

Do Not Write in this Space
For Revenue Receipting Only

Fees must be paid in the form of a cashier's check or money order, made payable to: Department of Health

Choose your application type:

- ☐ Change of Name (X-3010) **$25.00**
- ☐ Change of Location (X-3011) **$125.00**
- ☐ Change of Location and Name (X-3011) **$125.00**

Exisiting license number:

MM _____

1. BUSINESS INFORMATION

Business Name (d/b/a): _____ (as it should appear on license)

Corporate Name: _____ (If different than d/b/a name)

Mailing Address: **(The address where mail and your license should be sent.)**

_____ _____ _____
Street/ PO Box Suite/Apt. No City

_____ _____ _____ _____
State Zip Country Business Phone Number

Physical Location: **(This will be posted on the Department's website.)**

_____ _____ _____
Street/ PO Box Suite/Apt. No City

_____ _____ _____ _____
State Zip Country Business Fax Number

Choose your identification number below

- ☐ Federal Employer Identification Number (FEID): _____
- ☐ Social Security Number (SSN): _____ (If business does not have a FEID number)

Email Notification: If you want to be notified of the status of your application by email, please check the "Yes" box and write your email address on the line provided below. If you choose this form of notification, you will receive information regarding your application file through email. You will be responsible for checking your email regularly and updating your email address with the Board office at: info@floridasmassagetherapy.gov

I want to be notified by email: ☐ **Yes** ☐ **No**

Email Address: _____

Under Florida law, email addresses are public records. If you do not want your e-mail address released in response to a public records request, do not provide an email address or send electronic mail to our office. Instead contact the office by phone or in writing.

ESTABLISHMENT NAME _____

2. OPERATING HOURS

A. Will colonics be performed at this location? ☐ Yes ☐ No

B. Location Hours

☐ By Appointment Only
☐ Monday-Friday Open: _____ Close: _____
☐ Saturday Open: _____ Close: _____
☐ Sunday Open: _____ Close: _____

3. OWNERSHIP INFORMATION

A. Type of Ownership:

☐ Individual ☐ Corporation ☐ Partnership ☐ Other _____

If you selected **Corporation**, you must include with your application a copy of the Articles of Incorporation on file with the Florida Secretary of State's Office.

B. List the owner(s) of the establishment and all officers of the corporation as applicable.

Owner/Officer- Title	Date of Birth	Mailing Address, City, State, Zip Code	SSN

4. LICENSURE BACKGROUND

A. List any other name(s) by which any owner/officer has been known in the past.

_____

B. List all health related licenses any owner/officer has ever held (active, inactive or lapsed).

State/Country Profession License No. Date Of Licensure

_____
_____
_____
_____

5. DISCIPLINARY HISTORY

1. ☐ Yes ☐ No Has any owner/officer ever been issued a cease and desist agreement or citation for the unlicensed practice of massage therapy or operating an establishment without a license?

2. ☐ Yes ☐ No Has any owner/officer of the proposed establishment ever had a license or certificate of registration to practice massage therapy or any other licensed profession or a massage establishment license revoked, suspended or otherwise acted against (including but not limited to probation, fine, reprimand, or surrender of a license) in a disciplinary proceeding or in response to an investigation in any state?

3. ☐ Yes ☐ No Has any owner/officer of the proposed establishment ever had a license or certificate of registration to practice massage therapy or any other licensed profession or a massage establishment license denied for any reason in any state?

4. ☐ Yes ☐ No Is there currently pending against any owner/officer of the proposed establishment complaint or investigation in any state/jurisdiction for professional conduct or competence?

5. ☐ Yes ☐ No Has any owner/officer of the proposed establishment ever been a defendant in a civil litigation in which the basis of the complaint against you was an alleged negligence, malpractice, sexual misconduct or fraud?

6. CRIMINAL HISTORY

Answers to commonly asked questions can be found on our website at:
http://www.floridasmassagetherapy.gov/help-center/#faqs

If you answer "Yes" to any of the questions in this section, you are required to send the following items:

- **Self Explanation** describe the circumstances of each offense; include dates, location, charges and final results.
- **Final Dispositions and Arrest Records** for all offenses. The Clerk of the Court in the arresting jurisdiction will provide you with these documents. If unavailable, a letter stating such must come from the Clerk of the Court.
- **Completion of Sentence Documents**. You may obtain document from the Department of Corrections. The report must include the start date, end date and that the conditions were met.
- Three (3) current (written within the last year) professional **Letters of Recommendation**.

A. ☐ Yes ☐ No Has any owner/officer **EVER** been convicted of, or entered a plea of guilty, nolo contendere, or no contest to, a crime in any jurisdiction other than a minor traffic offense? You must include all misdemeanors and felonies, even if adjudication was withheld.
Reckless driving, driving while license suspended or revoked (DWLSR), driving under the influence (DUI) or driving while impaired (DWI) are not minor traffic offenses for purposes of this question.

B. ☐ Yes ☐ No Have charges ever been brought against any owner/officer by any branch of the United States Armed Services?

Failure to disclose information in this section may result in a denial of your application.

7. CRIMINAL AND MEDICAID/MEDICARE FRAUD QUESTIONS

Applicants for licensure, certification or registration and candidates for examination may be excluded from licensure, certification or registration if their felony conviction falls into certain timeframes as established in Section 456.0635(2), Florida Statutes. If you answer "Yes" to any of the following questions, please provide a written explanation for each question including the county and state of each termination or conviction, date of each termination or conviction, and copies of supporting documentation to the board office. Supporting documentation includes court dispositions or agency orders where applicable.

1. ☐ Yes ☐ No Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under Chapter 409, F.S. (relating to social and economic assistance), Chapter 817, F.S. (relating to fraudulent practices), Chapter 893, F.S. (relating to drug abuse prevention and control) or a similar felony offense(s) in another state or jurisdiction?

If you responded "No" to the question above, skip to question 2.

a. ☐ Yes ☐ No If "Yes" to 1, has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant successfully completed a drug court program for a felony offense that resulted in the plea being withdrawn or charges dismissed?

b. ☐ Yes ☐ No If "Yes" to 1, for felonies of the first or second degree, has it been more than 15 years before the date of application?

c. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree, has it been more than 10 years before the date of application, except for felonies of the third degree under Section 893.13(6), Florida Statutes?

d. ☐ Yes ☐ No If "Yes" to 1, for felonies of the third degree under Section 893.13(6)(a), Florida Statutes, has it been more than 5 years before the date of application?

2. ☐ Yes ☐ No Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been convicted of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, a felony under 21 U.S.C. ss. 801-970 (relating to controlled substances) or 42 U.S.C. ss. 1395-1396 (relating to public health, welfare, Medicare and Medicaid issues)?

If you responded "No" to the question above, skip to question 3.

a. ☐ Yes ☐ No If "Yes" to 2, has it been more than 15 years before the date of application since the sentence and any subsequent period of probation for such conviction or plea ended?

3. ☐ Yes ☐ No Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause from the Florida Medicaid Program pursuant to Section 409.913, Florida Statutes?

If you responded "No" to the question above, skip to question 4.

a. ☐ Yes ☐ No If the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant has been terminated but reinstated, has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been in good standing with the Florida Medicaid Program for the most recent five years?

4. ☐ Yes ☐ No Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant ever been terminated for cause, pursuant to the appeals procedures established by the state, from any other state Medicaid program?

If you responded "No" to the question above, skip to question 5.

a. ☐ Yes ☐ No Has the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant been in good standing with a state Medicaid program for the most recent five years?

b. ☐ Yes ☐ No Did the termination occur at least 20 years before the date of this application?

5. ☐ Yes ☐ No Is the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant currently listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities?

6. ☐ Yes ☐ No **If "Yes" to any of the questions 1 through 5 above,** on or before July 1, 2009, was the applicant or any principal, officer, agent, managing employee, or affiliated person of the applicant enrolled in an educational or training program in the profession in which you are seeking licensure that was recognized by the Board of Massage Therapy or Department of Health?

ESTABLISHMENT NAME _____

8. APPLICANT STATEMENT

I/ We do certify that I am/we are the person(s) referred to on the application as the Owner(s) or Corporate representative, if business is incorporated, and I/ We declare that the answers and all statements made by me/ us herein and in support of this application are true and correct. Should I/ we furnish any false information on or in support of this application, I/ we understand that such action shall constitute cause for denial, suspension, or revocation of any license to practice in the state of Florida in the profession for which I am/we are applying. I/ We hereby acknowledge that practice as a licensed Massage Establishment in Florida is governed by Chapters 456 and 480, F.S., and Rule Title 64B7, F.A.C. I/ We understand that it is my/our responsibility to operate this establishment in a safe and sanitary manner and to maintain insurance coverage as required by the Board's rules. I/ We understand that I am/ we are under a continuing obligation to understand and keep informed of any changes to Chapters 456 and 480, F.S., and Rule Title 64B7, F.A.C.

Applicant Signature: _____ **Date**: _____
This field cannot be typed. You must print the application and sign it. MM/DD/YYYY

All applications filed with the department are valid for one (1) year from the date of receipt.

You must pass an inspection by the Department of Health BEFORE you will be issued a license at the new location.

- A copy of the inspection form used by DOH inspectors can be found online here: http://floridasmassagetherapy.gov/applications/massage-app-sample-est-inspec.pdf
- Passing the inspection is NOT authorization for you to begin operation as a massage establishment at the new location
- You are NOT authorized to operate your establishment at the new location until you have been issued a license with the new location's address

FLORIDA BOARD OF MASSAGE THERAPY LICENSE VERIFICATION REQUEST

After completion of this form, please forward this form to the licensing agency of each state by which you are now or have been licensed.

Applicant Name: _____ FEID/ SSN: _____

Address: _____

Name original license was issued under: _____

License Number: _____State: _____

I hereby authorize release of any information regarding my licensure status to the Florida Board of Massage Therapy.

Applicant Signature: _____ Date: _____

STATE LICENSING AGENCY

All verifications shall be completed in English and mailed or sent electronically directly from the state(s) or jurisdiction(s) and must include the following criteria:

- □ Typed on an official state form or letterhead
- □ Include an official Board seal
- □ Signature and title of state Board official

The following information must be included in all verifications:

- □ Licensee name
- □ License number
- □ State or jurisdiction of licensure
- □ Dates of issuance/expiration
- □ Licensure method; exam type or endorsement
- □ Licensure status
- □ Is license in good standing?
- □ Has this license ever been encumbered (denied, revoked, suspended surrendered, limited, placed on probation)?

Complete verifications must be mailed or sent electronically directly from the state licensure Board to:

Florida Board of Massage Therapy
4052 Bald Cypress Way
Bin C-06
Tallahassee, FL 32399-3256

Fax (850) 412-2681
info@floridasmassagetherapy.gov

ESTABLISHMENT NAME: _____

CRIMINAL CONVICTION SELF EXPLANATION FORM

This form must be completed if you answer "YES" to any of the criminal history questions on the application. Please complete a separate form for EACH offense. Duplicate this form as necessary.

Name: _____

Social Security Number: _____

Level of Offense (Circle One): **Felony** **Misdemeanor**

Location of Occurrence: _____
City State

Date of Offense: _____ **Date of Sentencing:** _____

Offense Type (DUI, Battery, Prostitution, etc.): _____

Explanation/details surrounding the offense: What happened? What changes have you made? Attach additional sheets as necessary.

_____

_____

_____

_____

_____

Sentencing Information: Please list the details of your sentencing (I.e.: probation, jail time, fines/costs, programs completed, etc.)

_____

_____

_____

_____

_____

Current Disposition: Please list the current disposition of your sentencing.

_____

_____

_____

_____

Don't forget to attach documentation from the Clerk of Court pertaining to the arrest/charges, sentencing due to the arrest and proof of successful completion of your sentencing.