Application for
MASSAGE THERAPY CLINIC LICENSE
Village of Johnsburg

1. Is this application for renewal of an existing license? ________________ new license? ________________
2. Name under which business will be conducted: ____
3. Address of clinic: ____
4. Clinic telephone number: _______________________________
5. Are premises leased? Yes ________ No ________
   If yes, include copy of the lease agreement.

   If leased, full name of owner: ____

   Address: _______________________________________ City: ______________________________ State: ____________

   Zip Code: ________________________ Phone: ________________________
   If more than one owner, attach a separate sheet with name, address, and phone for each.
6. Are premises held in trust? Yes ________ No ________

   If held in trust, name ____

   Address: _______________________________________ City: ______________________________ State: ____________

   Zip Code: ________________________ Phone: ________________________
7. Description of proposed massage therapy clinic (include a floor plan for the facility):

   ____
   ____
   ____
   ____
   ____
   ____
8. Other activities or business conducted at this location:

   ____
   ____
   ____
   ____
   ____
   ____
9. Is applicant a:
   Sole Proprietorship _______ Partnership _______ Corporation _______

   If applicant is Sole Proprietorship:

   Full Name: ____

Home Address: ____

City: ____________________________________ State: _____________

Zip Code: __________________________________ Home Phone: _________________________________

Social Security #: ____________________________ Drivers License #: ______________________________

Date of Birth: ________________________________ Sex: M _____ F _____

Height: _________ Weight: _________ Hair Color: _______________ Eye Color: _______________

Nickname or Aliases: ____

If applicant is a Partnership: Date of Formation ______________________________
List the following for all general partners and any limited partner owning more than 20 percent of the aggregate limited partner interest in such partnership.

Partner Number 1
Full Name: ____

Home Address: ____

City: ____________________________________ State: _____________

Zip Code: __________________________________ Home Phone: _________________________________

Social Security #: ____________________________ Drivers License #: ______________________________

Date of Birth: ________________________________ Sex: M _____ F _____

Height: _________ Weight: _________ Hair Color: _______________ Eye Color: _______________

Nickname or Aliases: ____

Partner Number 2
Full Name: ____

Home Address: ____

City: ____________________________________ State: _____________

Zip Code: __________________________________ Home Phone: _________________________________

Social Security #: ____________________________ Drivers License #: ______________________________

Date of Birth: ________________________________ Sex: M _____ F _____

Height: _________ Weight: _________ Hair Color: _______________ Eye Color: _______________

Nickname or Aliases: ____

If applicant is a Corporation: Date of Formation ________________________________

If not an Illinois Corporation, the qualifying date with Illinois Business Corporate Act: ______________________________

List the following for the registered agent and for each officer, director and stockholder owning in the aggregate more than 20 percent of stock in of the corporation.

Number 1
Full Name: ____

Home Address: ____

City: ____ State: _______________

Zip Code: _____________________________________ Home Phone: ____________________________________

Social Security #: _______________________________ Drivers License #: _________________________________

Date of Birth: __________________________________ Sex: M ______ F ______

Height: __________ Weight: __________ Hair Color: ________________ Eye Color: ________________

Nickname or Aliases: ____

Number 2
Full Name: ____

Home Address: ____

City: ____ State: _______________

Zip Code: _____________________________________ Home Phone: ____________________________________

Social Security #: _______________________________ Drivers License #: _________________________________

Date of Birth: __________________________________ Sex: M ______ F ______

Height: __________ Weight: __________ Hair Color: ________________ Eye Color: ________________

Nickname or Aliases: ____

Number 3
Full Name: ____

Home Address: ____

City: ____ State: _______________

Zip Code: _____________________________________ Home Phone: ____________________________________

Social Security #: _______________________________ Drivers License #: _________________________________

Date of Birth: __________________________________ Sex: M ______ F ______

Height: __________ Weight: __________ Hair Color: ________________ Eye Color: ________________

Nickname or Aliases: ____

If more than three officers, directors or stockholders are present, include separate sheet for each.

10. Will business at the clinic be conducted by a manager? Yes ________ No ________

Manager
Full Name: ____

Home Address: ____

City: ____ State: _______________

Zip Code: _____________________________________ Home Phone: ____________________________________

Social Security #: _______________________________ Drivers License #: _________________________________

Date of Birth: __________________________________ Sex: M ______ F ______

Height: __________ Weight: __________ Hair Color: ________________ Eye Color: ________________

Nickname or Aliases: ____

Assistant Manager
Full Name: ____

Home Address: ____

City: ____ State: _______________

Zip Code: _____________________________________ Home Phone: ____________________________________

Social Security #: _______________________________ Drivers License #: _________________________________

Date of Birth: ___________________________________ Sex: M ______ F ______

Height: __________ Weight: __________ Hair Color: ________________ Eye Color: ________________

Nickname or Aliases: ____

11. List the following for each Massage Therapist:

Therapist 1
Full Name: ____

Massage Therapist License Number: ____

Home Address: ____

City: ____ State: _______________

Zip Code: _____________________________________ Home Phone: ____________________________________

Social Security #: _______________________________ Drivers License #: _________________________________

Date of Birth: ___________________________________ Sex: M ______ F ______

Height: __________ Weight: __________ Hair Color: ________________ Eye Color: ________________

Nickname or Aliases: ____

Therapist 2
Full Name: ____

Massage Therapist License Number: ____

Home Address: ____

City: ____ State: _______________

Zip Code: _____________________________________ Home Phone: ____________________________________

Social Security #: _______________________________ Drivers License #: _________________________________

Date of Birth: ___________________________________ Sex: M ______ F ______

Height: __________ Weight: __________ Hair Color: ________________ Eye Color: ________________

Nickname or Aliases: ____

Therapist 3
Full Name: ____

Massage Therapist License Number: ____

Home Address: ____

City: ____ State: _______________

Zip Code: ____________________________________ Home Phone: ___________________________________

Social Security #: ______________________________ Drivers License #: ________________________________

Date of Birth: _________________________________ Sex: M ______ F ______

Height: __________ Weight: __________ Hair Color: ________________ Eye Color: ________________

Nickname or Aliases: ____

If more than three massage therapists are present, include a separate sheet for each.

12. State the occupation, business name and date of employment of the applicant(s) for the three (3) previous years.

Applicant's Name	*Occupation*	*Business Name*	*Date of Employment*

13. Has the applicant ever been previously issued a Massage Therapist or Massage Therapy Clinic License by the Village that has since been revoked for cause?

No _________ Yes ________ If yes, state reason(s): ____

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14. List all convictions of the applicant(s) and manager(s) for the proposed clinic. All individuals as provided in section 9, 10 and 11 of this application shall be included. Such listing shall include the following:

All convictions other than minor traffic convictions.

A misdemeanor or licensing ordinance violation, based upon conduct of involvement in such business, activity or related or similar business or activity within the past ten (10) years.

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15. Attach two (2) passport size photographs (1" x 1-1/2") of the applicant (head and shoulders face forward).

16. Attach proof of United States Citizenship, Permanent Resident Alien Status, or a valid work permit.

17. Attach Proof of Professional Liability Insurance in an amount of not less than $1,000,000 per each occurrence.

In the event applicant is made aware that any information or document submitted as part of this application is inaccurate or incomplete, applicant shall immediately notify the Village and provide appropriate corrections. Failure to accurately and completely provide, or as necessary update, required information may delay the processing of such application or result in its denial.

____ _______________________________________
Signature of Applicant Date

____ _______________________________________
Signature of Applicant Date