



**MESSAGE OPERATOR'S  
PERMIT APPLICATION**  
 Community Development Department  
 Planning Division  
 10890 San Pablo Avenue  
 El Cerrito, CA 94530  
 (510) 215-4330 FAX (510) 233-5401  
 planning@ci.el-cerrito.ca.us

<b>Application No:</b>	
<b>Date Received:</b>	

## PART I – FOR ALL APPLICANTS

### A. APPLICANT INFORMATION

*If the business is a corporation or partnership, one officer or general partner shall be designated to act as the applicant.*

Applicant's name:	Phone:
Residence address:	
Mailing address (if different):	
Email address:	

*Along with this form, please submit a photocopy of one of the following types of photographic identification: California Driver's License, California Identification Card, U. S. Passport, or foreign passport. Bring the original identification card with you to show to staff.*

Type of identification provided:	Number:
Staff use: Above identification shown to staff: <input type="checkbox"/> Yes <input type="checkbox"/> No	

### B. MESSAGE BUSINESS – LOCATION AND CONTACT INFORMATION

Business name:
Business address ( <i>location where services will be provided or business will be based</i> ):
Mailing address ( <i>if different than business address</i> ):
Telephone numbers (list all):
Does this business have a website? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide web address: _____
Is this a new or existing message business? <input type="checkbox"/> New <input type="checkbox"/> Existing. Month and year established: _____
Is this a home occupation ( <i>a business operated out of the owner's home</i> )? <input type="checkbox"/> Yes <input type="checkbox"/> No
Staff Use: Zoning district of the business location: _____

**C. BUSINESS OWNERSHIP**

Form of ownership of the massage business:

- Individual/sole proprietorship
- General partnership
- Limited partnership
- Joint venture
- Limited liability corporation
- Corporation
- Cooperative
- Other: \_\_\_\_\_

***Sole Proprietorships***

If the business is a sole proprietorship, provide the following information.  N/A

Name of business owner/operator:
Residence address of business owner/operator:

***Partnerships***

If the business is a partnership, list the name and residence address of each partner, including limited partners, below. Attach additional sheets if necessary.  N/A

Name	Residence Address

*If business is a partnership, and one of the partners is a corporation, please also provide the information requested below for the corporation. If business is a limited partnership, include a copy of its certificate of limited partnership filed with the Secretary of State. All partners shall sign this application. See end of application for signature block.*

***Corporations***

If the business is a corporation, provide the following information.  N/A

Date of incorporation:	State where incorporated:
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List the name and residence address of each officer and director of the corporation, as well as each stockholder who owns more than 10 percent of the stock of the corporation. Attach additional sheets if necessary.

Name	Residence Address

**Corporations continued**

Name	Residence Address

All officers or directors of the corporation shall sign this application. See end of application for signature block.

**D. BUSINESS OWNER CAMTC CERTIFICATION**

Does every business owner hold certification from California Massage Therapy Council (CAMTC)?

<input type="checkbox"/> Yes. CAMTC certification number(s):	Date(s) issued:
<input type="checkbox"/> No. <i>If any owner is not CAMTC certified, please complete both Part I and Part II of the Massage Operator's Permit Application.</i>	

**E. BUSINESS OPERATION AND SERVICES**

Proposed days and hours of operation:
Describe the type of massage or other services to be provided:

Which of these services and facilities will be provided as part of the business? Check all that apply.

- |   |   |
|---|---|
| <input type="checkbox"/> Massage therapy                                | <input type="checkbox"/> Cosmetics consultation                                     |
| <input type="checkbox"/> Foot massage                                   | <input type="checkbox"/> Sauna  |
| <input type="checkbox"/> Acupressure                                    | <input type="checkbox"/> Steam room   |
| <input type="checkbox"/> Reflexology                                    | <input type="checkbox"/> Baths or hot tubs  |
| <input type="checkbox"/> Cupping therapy                                | <input type="checkbox"/> Aromatherapy   |
| <input type="checkbox"/> Energy healing or reiki                        | <input type="checkbox"/> Yoga or other movement (classes or individual instruction) |
| <input type="checkbox"/> Facials or other skin treatments               | <input type="checkbox"/> Other services (specify):                                  |
| <input type="checkbox"/> Waxing or other hair removal                   | _____   |
| <input type="checkbox"/> Nail treatments                                | _____   |
| <input type="checkbox"/> Hair cutting, coloring, styling, or treatments | _____   |

**Massage Practitioners**

Number of employees who will provide massage at the business location (or off site as part of the business): \_\_\_\_\_

Number of independent contractors who will provide massage at the business location (or off site as part of the business): \_\_\_\_\_

List below all employees or independent contractors who will perform massage at the site. Attach additional sheets if necessary.

First Name	Middle Name	Last Name	CAMTC Certificate Number	Staff use: CAMTC certification verified?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

**Other Employees or Contractors**

Number of other employees or contractors who will work at the business location but not perform massage:

\_\_\_\_\_

List below all employees who will work at the site but not perform massage. Attach additional sheets if necessary.

First Name	Middle Name	Last Name	Position and responsibilities

**F. FLOOR PLAN OF BUSINESS**

Along with this application form, submit a floor plan, drawn to scale, that shows the layout of the proposed business. Show all rooms, including massage therapy rooms, spa rooms, restrooms, reception areas, storage rooms, and any other rooms. Label the function of each room. Include walls, doors, windows, sinks, and toilets. Also show where massage tables or other major furniture will be placed.

**G. SIGNS**

Will any new business signs be installed or will any existing signs be modified?  Yes  No.

*If new signs will be installed, design review will likely be required. Please consult with Planning Division staff for information.*

**H. APPLICANT’S STATEMENT AND SIGNATURE**

I have carefully read the questions in the foregoing application and have answered them completely, without reservation of any kind, and I declare, under penalty of perjury under the laws of the State of California, that my answers and all statements made by me herein and in support of this application are complete, true and correct. Should I furnish any false information on or in support of this application or fail to fully provide all requested information, I understand that such action shall constitute cause for denial, suspension, revocation, or action against my Massage Operator’s Permit.

I understand that I must report any of the following to the Community Development Director within three days of the occurrence:

1. Arrests of any practitioners or owners of the massage business for an offense other than a misdemeanor traffic offense.
2. Resignations, terminations, or transfers of practitioners employed by the massage business.

3. Any event involving the massage business or the massage practitioners employed therein that constitutes a violation of Chapter 8.10 of the El Cerrito Municipal Code or State of California or federal law.

I understand that the owner of a massage business shall be responsible for the conduct of employees and independent contractors who provide massage services. I understand that failure to comply with California Business and Professions Code Sections 4600 et seq., the provisions of Chapter 8.10 of the El Cerrito Municipal Code, or any local, state, or federal law, may result in the revocation of my Massage Operator's Permit.

***Applicant's Signature***

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Applicant's Printed name

\_\_\_\_\_  
Date

***Additional Signatures***

If the business is a partnership, this application shall be signed by all partners. If the business is a corporation, this application shall be signed by all officers or directors. If the business is a joint venture, this application shall be signed by all participants. Attach additional sheets if necessary.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to business

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relationship to business

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Date

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Signature

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Relationship to business

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Printed name

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Date