



Massage Therapist License Application

12350 W 87 Street Pky
 P.O. Box 14888
 Lenexa, KS 66285-4888

Phone 913-477-7500
 Fax 913-477-7730
 www.ci.lenexa.ks.us

PLEASE PRINT AND ATTACH ADDITIONAL PAGES IF NECESSARY

New Application Renewal Application - Previous License Number: _____

THERAPIST'S PERSONAL INFORMATION

Name of Applicant _____
First Middle Last

Home Address _____
City State Zip

Home Tel () _____ Cell () _____ Fax () _____

Date of Birth _____ Driver's License # _____ State Issuing _____

Email _____ Social Security # _____ Gender: M F

Height _____ Weight _____ Eye Color _____ Hair Color _____ Race: _____

Position or function (be specific): _____

PREVIOUS THREE (3) YEARS' EMPLOYMENT HISTORY

Dates	Employer	Employer Address	Direct Supervisor	Supervisor's Direct Phone #
From: To:				
From: To:				
From: To:				
From: To:				
From: To:				

• **Have you ever had a Massage Therapist license or permit?**

No Yes (please provide location – city and state – for each previous license or permit held:

• **Have you ever had a Massage Therapist License denied, suspended or revoked?**

- No Yes (please complete the following information):

Year of Occurrence	City/State	Check Appropriate Box			Brief Explanation
		Denied	Suspended	Revoked	

• **Have you ever been convicted, diverted, had a suspended imposition of a sentence, or other similar adjudication, of a criminal charge?**

- No Yes (please complete the following information):

Date	Charge	Jurisdiction	Sentence/Penalty	Status of Case

• **Educational Requirements – proof of the following is required with this application:**

- New application - 500 hours in a massage-related course of instruction OR 100 hours in a massage-related course of instruction plus be a State-licensed healthcare professional
 - Current certification in CPR and First Aid by the American Heart Association or the equivalent
- Renewal application - 12 hours continuing education from an accredited college or university
 - Current certification in CPR and First Aid by the American Heart Association or the equivalent

I will provide in-office massage therapy (conducted on the premises of therapist’s business clients)

I will be employed by:

Name of Business _____ Owner of Business _____

Business Address _____ Lenexa, KS _____
Zip

Business Tel () _____ Cell () _____ Business Fax () _____

Email _____

I hereby swear or affirm that the information provided on this application, and any other documentation provided to the City in support of this application, is true and correct to the best of my knowledge and belief. I further acknowledge that if any information provided is determined to be false

or misleading, that alone shall be grounds for the denial, suspension, or revocation of the license. I further authorize the City to conduct an investigation into the truth of the statements set forth in this application and any other documentation submitted in support of this application.

Applicant Signature _____ Date _____

Notary Public _____ My appointment expires (seal) _____

Subscribed and sworn to before me this _____ day of _____, 20____.

FOR OFFICE USE ONLY:

Ord 12493 License effective from _____ to _____
Yearly Fee \$35 Fee Remitted _____ Cash / cc / Check # _____ Receipt # _____

Police Dept. Approval _____ Business License No. _____