

Business Services

Office location - 7447 E. Indian School Road, Suite 110
Scottsdale, Az. 85251

Telephone - (480) 312-2400

Web - www.ScottsdaleAZ.gov/licenses



Fee(s) _____

General Provisions
Ordinance to Applicant
Date & Initial

Message Ordinance to
Applicant Date & Initial

License Number

City of Scottsdale MESSAGE FACILITY APPLICATION

NOTE: ACCURACY IS IMPORTANT -- PLEASE TYPE OR PRINT IN INK

To Applicant: Check all your answers for accuracy. False or incomplete answers or omissions may result in non-acceptance, denial or subsequent revocation of a license. If questions are not applicable to you or your business, enter "N/A" as a response.

<p>SECTION 1 (Check one) This application is for a:</p> <p><input type="checkbox"/> New License <input type="checkbox"/> Renewal of Existing License <input type="checkbox"/> Location Transfer <input type="checkbox"/> Name Change Only <input type="checkbox"/> Information Update</p>	<p>SECTION 2 (Check one) Type of ownership:</p> <p><input type="checkbox"/> Individual <input type="checkbox"/> General Partnership or Limited Partnership <input type="checkbox"/> Corporation or Limited Liability Company <input type="checkbox"/> Other _____</p>
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SECTION 3

- Applicant: _____
Last First Middle
- Business Name: _____
- All Business Phone(s): _____ Mobile Phone: _____
- Email Address:** _____
- Complete Business Address: _____
- Complete Mailing Address: _____

SECTION 4

- List all local on-site manager(s): Submit supplemental form, fingerprint card and processing fee

Last Name, First Name, MI	Residence Complete Address	Phone Number(s)

SECTION 5 Individual, General Partnership, or Limited Partnership *(Circle One)* List each owner, partner or member. Attach additional sheets as necessary to disclose additional persons.

1. Each person listed must submit a supplemental form, fingerprint card and a processing fee.

Title/Position	Last Name, First Name, MI	% Owned	Residence Complete Address

2. Is any person, other than those persons listed in Section 5, Number 1, going to share in the profits/losses of the business? Yes/No *(Circle One)* If Yes, List below:

Title/Position	Last Name, First Name, MI	% Owned	Residence Complete Address

SECTION 6 Corporation/Limited Liability Company/Other _____ *(Circle One)*

1. Name of Business Entity: _____
 (Exactly as it appears on Articles of Incorporation or Organization)

2. Date of Incorporation/Organization: _____ State where Incorporated/Organized: _____

3. AZ C.C. File No _____ Date authorized to do business in Arizona: _____

4. AZ L.L.C. File No. _____ Date authorized to do business in Arizona: _____

5. Is Corp./L.L.C./Other a non-profit? Yes/No *(Circle One)* If yes, give IRS tax exempt number: _____

6. Are you an agent designated by a publicly traded corporation to act on behalf of the corporation under the City of Scottsdale Ordinance? Yes No

7. Name of Local Agent: _____ Phone: _____

Complete Address of Local Agent: _____

Is the Local Agent a legal resident of the State of Arizona? Yes No

8. List each officer, member, controlling person or other positions held in the corporation, LLC. If necessary, attach an additional sheet of paper. Each person listed must submit a Massage Facility Supplemental Questionnaire, be fingerprinted, and pay a records check fee.

Title/Position	Last Name, First Name, MI	% Owned	Residence Complete Address

9. If the corporation/L.L.C./Other is owned by another entity, attach a list of each officer, member, controlling person or other position held in the parent entity. Attach additional sheets as necessary to disclose controlling persons in the business. Each person listed must submit a Massage Facility Supplemental Questionnaire.

SECTION 7 Creditors/Private Investors/Onsite Manager/Manager (*Circle One*) Attach an addition sheet as necessary to disclose additional person.

List any creditor or person not previously disclosed who owns more than 10% of the beneficial interest in this business.

Title/position	Last Name, First Name, MI	% Owned	Residence Complete Address

SECTION 8 List any other Controlling Person(s) as defined in the attached supplemental information sheet, if not previously listed in section 4, 5, 6 or 7.

Title/Position	Last Name, First Name, MI	% Owned	Residence Complete Address

SECTION 9 Location transfer – **Applicants cannot operate under a location transfer until it is approved by the City.**

1. Previous Business Name: _____
2. New Business Name: _____
(If applicable)
3. New Business Location: _____
4. Previous Business Location: _____

Planned date of opening at new location: _____ New Business Phone: _____

SECTION 10

Do you own your business location? ___ Yes ___ No Is this a residence? ___ Yes ___ No

Landlord/Property Owner information: Name: _____ Phone #: (____) ____ - _____

Landlord/Property Owner Complete Address: _____

Do you rent a portion of your business premises to another entity? ___ Yes ___ No

SECTION 11

1. Attach a current and complete "All Employee Log" form as provided by the City of Scottsdale Tax & License Registration office.
2. Attach a signed copy of the Certification of Compliance that the facility complies with all requirements listed in the City of Scottsdale Massage Ordinance. This certification is provided by the City of Scottsdale.
3. Attach a Massage Facility Supplemental Questionnaire for each person listed on the Massage Facility application.
 - a. Each person must provide a copy of a government issued photo identification (a valid Drivers License or Passport) as proof of age.
 - b. Each person must provide proof of U.S. citizenship or lawful residency of the United States authorized to work in the United States.

I hereby certify that all answers to questions on this questionnaire are true and complete, and I agree and understand that any falsification of material facts may cause forfeiture on my part of all rights to, and consideration to be licensed in the City of Scottsdale, County of Maricopa, State of Arizona.

Print Name

Signature

Date

All Employee Log As Of _____

Date

Name of Facility: _____ Facility Address: _____ Facility License No. _____

Employee's Full Legal Name: _____

Last

First

Middle

Date of Birth

Complete Home Address: _____

City

State

Zip Code

Home Telephone No. () _____ - _____ State of Arizona Therapist License No. _____ Expiration Date: _____

Employment Position: _____ Date Employment Began: _____ Date Employment Terminated: _____

Employee's Full Legal Name: _____

Last

First

Middle

Date of Birth

Complete Home Address: _____

City

State

Zip Code

Home Telephone No. () _____ - _____ State of Arizona Therapist License No. _____ Expiration Date: _____

Employment Position: _____ Date Employment Began: _____ Date Employment Terminated: _____

Employee's Full Legal Name: _____

Last

First

Middle

Date of Birth

Complete Home Address: _____

City

State

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Home Telephone No. () _____ - _____ State of Arizona Therapist License No. _____ Expiration Date: _____

Employment Position: _____ Date Employment Began: _____ Date Employment Terminated: _____

Employee's Full Legal Name: _____

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First

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Date of Birth

Complete Home Address: _____

City

State

Zip Code

Home Telephone No. () _____ - _____ State of Arizona Therapist License No. _____ Expiration Date: _____

Employment Position: _____ Date Employment Began: _____ Date Employment Terminated: _____

CERTIFICATION OF COMPLIANCE

License # _____

I, _____, _____ certify that the massage facility
Name Title
_____, located at _____
Business Name Business Address

complies with all of the following minimum requirements set forth in section 16-210:

- a) Minimum lighting requirements shall be provided in accordance with Chapter 31 of the City Code. In addition, artificial light not less than four hundred (400) lumens, which is not shaded to significantly decrease luminosity, shall be provided in each room or quarters where massage therapy is performed on clients and shall be in use whenever massage therapy is being performed.
- b) Minimum ventilation shall conform with Chapter 31 of the city code.
- c) All instruments used in administering or practicing any massage therapy shall be sterilized after each use.
- d) Closed cabinets shall be provided and used for the storage of clean linens. Used linens shall be placed in a closed cabinet or hamper separate from clean linens.
- e) Except when the client is fully clothed and the massage therapy is administered in a full public view, dressing and toilet facilities, including hot and cold running water, shall be provided for clients as follows: a dressing room and a minimum of one (1) toilet and one (1) wash basin. The toilet and wash basin shall be located in the massage facility, or in a public restroom, not used in connection with a commercial business, within one hundred fifty (150) feet of the massage facility. If both male and female clients are to be served simultaneously at the massage facility, however, a separate massage room or rooms, and separate dressing facilities shall be provided for male and female clients.
- f) All walls, ceilings, floors, pools, showers, bathtubs, hot tubs, steam rooms and all other physical facilities for the massage facility shall be in good repair and maintained in a clean and sanitary condition. Wet and dry heat rooms, steam or vapor rooms, steam or vapor cabinets, shower compartments, and toilet rooms shall be thoroughly cleaned each day the business is in operation. Bathtubs shall be thoroughly cleaned after each use. Among other conditions, evidence of regular cooking, dirty dishes, pots and pans, cooking utensils, food, mattresses or beds used for overnight sleeping, and exposed used or dirty linens in areas used for massage therapy, shall be considered evidence of unclean and unsanitary conditions.
- g) Clean and sanitary towels shall be provided for each client of the massage facility. Each table used for massage therapy shall be provided with a clean and sanitary towel, paper towel or sheet for each client.
- h) An on-site manager shall be at the massage facility at all times when massage therapy is being performed.
- i) The on-site manager shall have, available on request, the city-issued identification card at all times when the on-site manager is on duty at the massage facility.
- j) The massage facility shall comply with all applicable provisions of the city fire code and zoning ordinance.

Signature

Date



**ACKNOWLEDGMENT of UNDERSTANDING
REGULATORY LICENSES**

For licenses requiring Fingerprinting and subsequent background check

License Application # _____

DATE: _____

Business Name _____

On behalf of the above referenced license, I understand and agree to communicate to all parties that this application is subject to an approval process that can take up to 90 days.

I understand and agree to communicate to all parties that the business cannot operate until approval notice is received.

Representative / Applicant Name: _____

Representative / Applicant Title: _____

Signature: _____

CSR Initials _____



Massage Facility Interpreter Application Certification

I certify under penalty of A.R.S. §13-2704(A)(1), that I am fluent in English and _____ which is the native language of the applicant/owner/manager. I have read to the applicant/owner/manager in his/her native language every question and instruction on this application and his/her answer to every question. The applicant/owner/manager informed me that he/she understands every instruction, question and answer on the application including the massage facility special requirements and ordinance requirements and has verified the accuracy of every answer.

Name of Applicant: _____

Name of Owner/Manager (if different from above): _____

Name of Interpreter: _____

Mailing Address _____

Telephone Number: _____

Email Address: _____

No Interpreter Applicant Signature: _____

Interpreter Signature: _____

Date: _____

Office Use Only - Massage Facility License # _____