



St. Joseph County Department of Health

"To promote health and wellness with compassion and integrity through partnerships, education, protection, and advocacy for all who reside in and visit St. Joseph County."

ST. JOSEPH COUNTY
DEPARTMENT OF HEALTH
Prevent. Promote. Protect.

APPLICATION FOR RENEWAL: MASSAGE THERAPIST LICENSE

1. Name of Applicant: _____
2. Local Home Address, City and Zip: _____
3. Local Phone #: _____ Mobile #: _____
4. Date of Birth: _____ E-Mail Address: _____
5. Name and Address of Establishment(s), if any, at which you are or expect to be employed:

Establishment Name	Address	City	State	Zip
_____	_____	_____	_____	_____

5. **Further requirements for completion of this application:**

- a. A fee of one hundred dollars (**\$100.00**) is to accompany this annual renewal application due every February. A late fee of 25% per month will be assessed.
- b. Provide a copy of a current Massage Therapist License from the Indiana State Board of Massage Therapy.
- c. Provide a current valid driver's license or government-issued photo identification.
- d. Must **INCLUDE** a self-addressed stamped envelope to obtain the license.

No Personal Checks Accepted. We will accept Money orders, Cashier's checks, Business checks, Visa, MasterCard or Discover. Please Note: We are not able to process credit card transactions by phone or by mail.

I certify that the information provided above is true and accurate. I understand that failure to provide true and accurate information is a violation of County Code 113 and may result in the cancellation of my license and assignment of financial penalties of up to \$1,500 per violation, per day. I certify that I will not perform massage therapy in a residence or an establishment that does not possess a Massage Establishment License (certain exceptions apply, such as medical facilities).

Signature: _____ Date: _____

FOR OFFICE USE ONLY!		
Date Paid: _____	Fee Paid: _____	
Transaction #: _____	Late Fee: _____	
Dept Employee: _____	Total Paid: _____	
Mailed: _____ Walk-IN: _____	SR/License #: _____	

Please send all electronic correspondence for the Environmental Health Unit to envirohd@sjcindiana.com