

CITY OF FAIRFAX POLICE DEPARTMENT
PERMIT APPLICATION – MESSAGE THERAPIST (Section 14-351, City Code)
(MESSAGE THERAPIST PERMIT SHALL BE VALID FOR TWO YEARS FROM DATE OF ISSUANCE)

Last			First			Middle			Email (to facilitate communication)	
NAME:										
Alias / Nicknames / Maiden Name						*Social Security #			Personal Telephone	
Address						City			State	ZIP
Race	Sex	DOB		Place of Birth		Ht.	Wt.	Eyes	Hair	Age
Name of Massage Establishment									Telephone	
Address of Establishment										
Current (or most recent) Employer									Telephone	
Address										

(* Not required, used to verify criminal history information)

Names and addresses of any and all massage establishments where you have been employed as a massage technician within past three years. Use an additional form for more space, if needed.

Name of Establishment	Address	Dates of Employment

I have been convicted of, plead Nolo Contendere, or am under pending charge(s) or indictment(s) for the following crimes, other than misdemeanor traffic violations, either within or outside the Commonwealth of Virginia. List all charges; use an additional form if necessary.

Yes No If yes, give details below:

Charge <input type="checkbox"/> Felony or <input type="checkbox"/> Misdemeanor	Date	Jurisdiction (county & state)	Disposition
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Charge <input type="checkbox"/> Felony or <input type="checkbox"/> Misdemeanor	Date	Jurisdiction (county & state)	Disposition

Do you hold or have you previously held a permit or license to offer or administer massages anywhere in Virginia or in any other locality? Yes No

If yes, provide the issuing jurisdiction(s), license or permit number(s), and date(s) issued.

Issuing Jurisdiction	License or Permit Number	Date Issued

Has any license or permit been revoked or suspended and, if so, the circumstances of such revocation/suspension.

Yes _____ No _____

Circumstances: _____

Routing List	√	Date	Initials
Application Issued			
Application Received			
Permit Fee Paid (\$100.00 for 2 years)			
Fingerprints (Original application only, if original permit has remained valid)			
Photograph			
Police Dept. Records Check Completed (VCIN)			
Copy of Certification			
Permit Issued			
Permit Revoked			
Appeal			
Warrant Check (10-29)			

I swear (affirm) that all of the above information is true and correct to the best of my knowledge.

I understand that it is unlawful for any person to make a false statement on this application and discovery of a false statement shall constitute grounds for denial of an application or revocation of a permit.

Signature of Applicant

Sworn before me this _____ day of _____ 20__

(Notary Public)

My Commission Expires _____

Each holder of a massage therapist permit shall report to the Chief of Police any change in any of the information required in subsection (a) of this section, such report to be made within fourteen (14) days of learning of the change. Failure to report a change after learning of it shall be grounds for revocation of the permit.

OFFICE USE ONLY

FEE \$ _____ RECEIPT NO. _____ PERMIT NO. _____

APPROVED _____ DISAPPROVED _____

DATE _____

REMARKS: _____
