CITY AND COUNTY OF SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
ENVIRONMENTAL HEALTH SECTION – MASSAGE PROGRAM
1390 Market Street, Ste #210
San Francisco, CA 94102
Phone: 415-252-3882

REQUEST FOR VERIFICATION OF MASSAGE LICENSE

TO BE COMPLETED BY APPLICANT

Instructions: 1. Applicant – Complete upper portion of form and forward to each state where you have been licensed, certified, or registered as a massage therapist. (This form may be photocopied if necessary). 2. The licensing agency is to complete lower portion of form and submit it DIRECTLY to the City and County of San Francisco in an envelope with the agency's return address printed on it. THIS FORM WILL NOT BE ACCEPTED IF RETURNED BY THE APPLICANT OR IF IT APPEARS THE APPLICANT HAS WRITTEN IN THE LOWER PORTION OF THE FORM.

Last Name **First Name** **Middle Name**

Street Address **City** **State** **Zip Code**

Type of License Granted **License #** **Date Issued**

I authorize the release of all pertinent information, favorable or otherwise, to the City and County of San Francisco - Department of Public Health.

Signature of Applicant_____

TO BE COMPLETED BY LICENSING AGENCY ONLY

This is to certify that the above named individual was issued license number: _____

Title of Applicant's License: _____ **Date License Issued:** _____

Lapsed/Expired on: _____ **Credential current through:** _____

Please answer the following questions. If the answer to any question is YES, explain on the reverse side of this form or attach appropriate documentation supporting your answer.

1. Has the applicant's credential ever been suspended or revoked? ☐ **Yes** ☐ **No**
2. Are there any complaints and/or disciplinary action taken or pending against this applicant? ☐ **Yes** ☐ **No**
3. Does this credential have any restrictions or limitations on it? ☐ **Yes** ☐ **No**

Signature of Official: _____ **Date:**_____

Printed Name of Official: _____

Official Title: _____ **Agency Seal**

Licensing Agency Name: _____

Mailing Address: _____

City: _____ **State:**_____ **Zip Code:** _____

Phone Number: _____