Outcall Massage Service Application:

Please fill out and provide the following:

- ☐ Application (page 2)
- ☐ Written Operational Procedures (page 3)
- ☐ San Francisco Police Department background check (page 4)

  Applicant must submit fingerprints to SFPD for state and federal level fingerprint-based background check. By appointment only. Email background check form to SFPDPERMITS@SFGOV.ORG. DO NOT MAIL IT IN.

  This is required for existing San Francisco massage practitioner license holder only. CAMTC certificate holders are not required to complete the SFPD background check.
- ☐ Copy of Business Registration Certificate
- ☐ Copy of SF Massage Practitioner License OR CAMTC certificate
- ☐ Copy of current Identification Card or Driver's License
- ☐ Mail completed forms with non-refundable application fee made payable to SFDPH (*check, money order, or cashier's check*) at:

  SFDPH - EHB (MASSAGE PROGRAM)
  49 South Van Ness Avenue, Suite 600
  San Francisco, CA 94103

PLEASE MAKE AN APPOINTMENT IF YOU WISH TO SPEAK WITH AN INSPECTOR. THERE ARE NO DROP-IN APPOINTMENTS.

Please Note: Failure to complete all forms and provide required documentation will result in your application being delayed or denied.

CITY AND COUNTY OF SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
ENVIRONMENTAL HEALTH BRANCH, 49 SOUTH VAN NESS AVENUE, SUITE 600, 94103

APPLICATION FOR PERMIT TO OPERATE A MASSAGE ESTABLISHMENT

Date of Application:

Type of Establishment: ☐ **General Massage** ☐ **OutCall Service** ☐ **Sole Practitioner**		**FACILITY ID NO.**
TRADE NAME (DBA): **ADDRESS:**	☐ Sole Owner ☐ Partnership ☐ Corporation	☐ New Installation ☐ Ownership Change ☐ Reclassification ☐ Record Purpose
CROSS STREET:	**EMAIL ADDRESS:**	**BUSINESS PHONE NO.** / **CELL PHONE NO.**

Name of: a) Person to whom permit will be issued, or b) Corporation name and names of principal Officers and stockholders with more than or equal to 10% ownership	**Home Address** of: a) each applicant with birth date, or b) each practitioner for Solo Practitioner Establishment, or c) Corporation and Corporate Officers **Contact Person:**
Emergency name & phone:	**Home Telephone:**

Has any applicant, including corporate officers and stockholders, **EVER BEEN CONVICTED OF ANY FELONY OR MISDEMEANOR** ☐ No ☐ Yes
If yes, please attach a list of each conviction along with the date of the conviction.

Are you currently pending any investigation regarding any felonies, misdemeanors or lewd conduct ☐ No ☐ Yes
If yes, please attach a list of each conviction along with the date of the conviction.

Have you ever had any massage license or massage establishment licenses denied, suspended or revoked: ☐ No ☐ Yes
If yes, please attach information about the license denial, revocation or suspension, inlcuding dates.

ATTACH:
1) WRITTEN OPERATIONAL PROCEDURES WHICH DESCRIBE THE EXACT NATURE OF THE SERVICES TO BE PROVIDED
2) PRACTITIONER LIST (FOR SOLO MASSAGE ESTABLISHMENTS) with Date of Birth.
3) LIST OF PREVIOUS MASSAGE PERMITS OR LICENSES HELD

I declare under penalty of perjury the information on this application and in other materials submitted in support of this application are true and correct. I hereby consent to all necessary inspections made pursuant to the Massage Ordinance and incidental to the issuance of any exemption, Registration or Permit, and operation of this business. I have checked with the Planning Department prior to submitting this application to verify that this location is zoned for a Massage Establishment. **I understand that once submitted, the application fee is nonrefundable.**

***SIGNATURE(S) OF APPLICANT(S)**

X _____ X _____

X _____ X _____

**If Partnership, all partners must sign. If Corporation, authorized Officer must sign. Attach extra sheets if necessary.*

FOR OFFICE USE ONLY

Filing Fee & Receipt #		Zoning Referral		Lease Agreement		Previous Permits	
Labor & Workers' Comp		Fire Dept Referral		Practitioner list		Home Addresses	
Out of Business Notification				Owner(s) Background Check		Corporate Address	

INSPECTOR'S REPORT

To the Director of Public Health:
After having made a careful inspection in the above case on _____ 20
I RECOMMEND the issuance of a New Permit to operate ☐
I DISAPPROVE the issuance of a New Permit to operate ☐ for the following reasons:

PRINCIPAL INSPECTOR **INSPECTOR**

HEARING DATE	APPROVED Y ☐ N ☐	DISTRICT NO.	CENSUS TRACT	PERMIT NO.	TYPE OF PERMIT / CLASSIFICATION

DATE: _____

WRITTEN OPERATIONAL PROCEDURES

DBA: _____ **Bus. Phone:** _____

Address: _____ **OnSite Mgr:** _____

MANAGER DURING NORMAL WORKING HRS

TYPE OF ESTABLISHMENT:	EMPLOYEES:	**OPERATIONS:**	**# OF ROOMS:**
☐ GENERAL WITHOUT OUTCALL ☐ GENERAL W/ OUTCALL ☐ SOLO WITHOUT OUTCALL ☐ OUTCALL ONLY ☐ SOLO WITH OUTCALL	TOTAL: _____ M _____ F _____	DAYS: _____ HOURS: _____	**THERAPY:** _____ **TOILET:** _____

DESCRIBE THE TYPE OF MASSAGE THERAPY USED BY YOUR PRACTITIONERS, (I.E. SHIATSU, SWEDISH, DEEP TISSUE, ETAL.)

IS THIS BUSINESS AN ACCESSORY TO AN EXISTING/NEW BUSINESS?	**ATTACH A FLOOR PLAN** OF YOUR ESTABLISHMENT SHOWING:
N ◯ Y ◯ IF YES, WHAT IS IT? _____	SHOWERS, TOILETS, THERAPY & CHANGE ROOMS, HANDWASH & MOP SINKS, AND CLEAN & DIRTY LINEN STORAGE.

I declare under penalty of perjury that the information on this business plan, to the best of my knowledge, is true and correct. I hereby consent to all necessary inspections made pursuant to the Massage Ordinance and incidental to the issuance of any exemption, Registration or Permit, and operation of this business.

NAME (PRINTED)	SIGNATURE	DATE

City and County of San Francisco
DEPARTMENT OF PUBLIC HEALTH
ENVIRONMENTAL HEALTH

To: San Francisco Police Department
Permits Unit
1245 3rd Street, 5th Floor,
San Francisco, CA 94158
Phone: (415) 553-1115
Email: sfpdpermits@sfgov.org
By Appointment Only

Subject: **BACKGROUND CHECK AND CLEARANCE FOR MASSAGE APPLICANT**

We have received the following applicant's information for:
- ☐ Outcall Service
- ☐ General Massage Establishment
- ☐ Sole Practitioner Massage Establishment

Applicant's Name:	Date:
Doing Business As (DBA):	BAN:
Facility Address:	
Home Address:	
Phone Number:	E-Mail:
Social Security #:	Place of Birth:
Driver's License # (or ID #/Passport #):	Date of Birth:
Eye Color: Hair Color: Height: Weight:	

*****DO NOT WRITE BELOW – FOR SFPD USE ONLY*****

SFPD, may we please have your recommendation in the space provided below.

Does the applicant qualify for First Year Free (FYF)? ☐ YES ☐ NO

A preliminary criminal background query has indicated:

☐ In the previous 5 years, the applicant **has not been** convicted of any offenses outlined in San Francisco Health Code Sections 29.29(c)(4) & (5), 29.12.

☐ In the previous 5 years, the applicant **has been** convicted of one or more of the offenses outlined in San Francisco Health Code Sections 29.29(c) (4) & (5), 29.12.

☐ The applicant has **any** prior felony or misdemeanor convictions. San Francisco Health Code Sections 29.26(b)(6) and 29.11(b)(7). (List Below)

Prior Felony or Misdemeanors: _____

_____

Reviewed by: _____
INSPECTOR (PRINT) STAR # SIGNATURE

Telephone no: _____ Date: _____

APPLICANT MUST SUBMIT FINGERPRINTS TO SFPD FOR THE PURPOSE OF STATE AND FEDERAL LEVEL FINGERPRINT-BASED BACKGROUND CHECK.PLEASE EMAIL THIS FORM TO SFPDPERMITS@SFGOV.ORG AND SFPD STAFF WILL CONTACT YOU TO SCHEDULE YOUR APPOINTMENT. YOU MAY CONTACT THE SFPD PERMITS UNIT FOR THE CURRENT BACKGROUND CHECK FEE.