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

London N. Breed, Mayor
Grant Colfax, MD, Director of Health

Patrick Fosdahl, MS, REHS
Director of Environmental Health

Sole Practitioner Establishment Permit Application

Please fill out and provide the following:

- ☐ Application (page 2)
- ☐ Written Operational Procedures (page 3)
- ☐ Practitioners' List (page 4)
- ☐ Referral to Fire Marshal (page 5)
- ☐ Referral to Planning/Zoning (page 6-7)
- ☐ San Francisco Police Department background check (page 8)
  Applicant must submit fingerprints to SFPD for state and federal level fingerprint-based background check. You must deliver the SFPD form in person along with payment to SFPD, 850 Bryant St., Rm 505. DO NOT MAIL IT IN. *Police Background check expires after three (3) months. CAMTC certificate holders are not required to complete the SFPD background check.*

- ☐ A copy of the lease, rental agreement or, if the applicant owns the premises, a copy of the deed.
- ☐ Floor plan drawing with dimensions depicting rooms and equipment.
  Submit 2 sets of floor plans on 11 x 17" paper for brand new establishments only.
- ☐ Copy of Business Registration Certificate
- ☐ Copy of SF Massage Practitioner OR CAMTC certificate
- ☐ Copy of current Identification Card or Driver's License

PLEASE MAKE AN APPOINTMENT TO SEE 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.**
TRADENAME (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 MASSAGE ESTABLISHMENTS)
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

DATE:_____

PRACTITIONERS' LIST FOR

◯ EXISTING ◯ NEW

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

Address:_____ **OnSite Mgr:**_____

MANAGER DURING NORMAL WORKING HRS

	FIRST & LAST NAME OF MASSAGE PRACTITIONER *Provide copy of current SF Massage Practitioner License Certificate or CAMTC Certificate*	PRACT. Check one	PERMIT# (MP)	Office Use ONLY Active?
1)		CAMTC ◯ DPH ◯		☐ YES ☐ No Permit
2)		CAMTC ◯ DPH ◯		☐ YES ☐ No Permit
3)		CAMTC ◯ DPH ◯		☐ YES ☐ No Permit
4)		CAMTC ◯ DPH ◯		☐ YES ☐ No Permit
5)		CAMTC ◯ DPH ◯		☐ YES ☐ No Permit
6)		CAMTC ◯ DPH ◯		☐ YES ☐ No Permit
7)		CAMTC ◯ DPH ◯		☐ YES ☐ No Permit
8)		CAMTC ◯ DPH ◯		☐ YES ☐ No Permit
9)		CAMTC ◯ DPH ◯		☐ YES ☐ No Permit
10)		CAMTC ◯ DPH ◯		☐ YES ☐ No Permit
11)		CAMTC ◯ DPH ◯		☐ YES ☐ No Permit
12)		CAMTC ◯ DPH ◯		☐ YES ☐ No Permit

PLEASE ATTACH ANOTHER PAGE IF THERE ARE MORE THAN TWELVE PRACTITIONERS AT THIS FACILITY.

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

DPH Fire Marshal Referral

Fire Marshal
Division of Fire Prevention & Investigation
698 2nd Street, Room 109
San Francisco, CA 94107

This section to be completed by Owner/Operator

Location: _____ DBA: _____ Bus. Type: _____

Change of ownership only and no change to previous operation: ◯ Yes ◯ NO
Is the occupancy or number of seats greater than 49? ◯ Yes ◯ NO
Do you have gas or open flame cooking equipment? ◯ Yes ◯ NO
Are you constructing a new facility? ◯ Yes ◯ NO
Are you remodeling the facility? ◯ Yes ◯ NO
Are you operating now? ◯ Yes ◯ NO
If no, what date do you anticipate opening:

Owner/Operator Name: _____ Owner Address: _____

Business Phone: _____ Email: _____ Cell to Arrange Inspection: _____

This section to be completed by Department of Public Health Staff

Date: _____ Inspector: _____ DPH Receipt #: _____

HD: _____ Phone: _____ Fax: _____

Fire Marshal, the business named above warrants your timely inspection for fire clearance:

☐ Fire clearance is required before approval and issuance of a new Health Permit for this type of facility.

☐ This facility was observed to have questionable or hazardous conditions: _____

_____

☐ For informational purposes only (No response required). Fire Inspection Fees to be collected by SFFD.

This section to be completed by SFFD Staff

☐ **Approved** Fire Safety

☐ **Disapproved** Fire Safety: _____

_____

☐ **Pending** Clearance: _____

_____

(Attach a copy of pending SFFD document or NOV)

Date: _____ Inspector: _____ Phone _____

POPULATION HEALTH DIVISION
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
ENVIRONMENTAL HEALTH

49 South Van Ness Avenue, San Francisco, CA 94103
Phone 415-252-3800, Fax 415-252-3875

Form updated 09/2021

HEALTH DEPARTMENT USE ONLY					
Date Application Filed:		Health District:	3 4 5 Massage OTHER		
Date to Zoning:		Inspector:		Phone	
Date from Zoning:		Supervisor's Initials:		Date:	

Please submit to:
CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH, ENVIRONMENTAL HEALTH
49 SOUTH VAN NESS AVENUE, STE. 600, San Francisco, CA 94103 - (415) 252-3800

Zoning Referral for Health Permit

1. Business Information

BUSINESS STREET ADDRESS:

NAME OF BUSINESS:

TOTAL SQUARE FOOTAGE OF AREA (includes storage and bathroom areas):	OUTDOOR SEATING AREA?	OUTDOOR FOOD/DRINK SERVICE?
	☐ Yes ☐ No	☐ Yes ☐ No

WHAT FLOOR OF THE BUILDING WILL THE BUSINESS OCCUPY?

☐ Ground (First) Level ☐ Second Level ☐ Third Level ☐ Other Level:

1a. Change of Use (depending of the zoning of the property, neighborhood notification may be required): ☐ Yes ☐ No
If yes, what is the existing use? _____

1b. Change of business ownership? ☐ Yes ☐ No
If not a change of ownership, then is it a new establishment? ☐ Yes ☐ No

1c. Is the establishment vacant? ☐ Yes ☐ No
If yes, how long was the establishment vacant? _____

1d. Do you propose to alter the interior or exterior of the establishment? ☐ Yes ☐ No
If yes, what is the Building Permit Application Number? _____

1e. Is the business a Formula Retail Chain or Franchise with 11 or more locations within the U.S.? ☐ Yes ☐ No
If yes, a Formula Retail Affidavit is **required**. (Formula Retail - P.C. Sec. 301.1)

1f. Does this business sell alcoholic beverages? ☐ Yes ☐ No
If yes, read page two for category restrictions.

2. Type of Operation, please check:

☐ **Restaurant** ☐ **Limited Restaurant**

☐ **Bar** ☐ **General / Specialty Grocery**

☐ **Catering** ☐ **Cottage Food Operator**

☐ **Massage** *(if applicable, please select your type of massage business below)*

☐ Chair/Foot Massage Only ☐ Sole Practitioner Establishment ☐ Within a gym, hotel, or hospital

☐ **Other:**

2a. Accessory Use (business within another business)? ☐ Yes ☐ No **If yes, plans are required.**

2b. Days / Hours of Operation:

_____

3. Applicant's Affidavit

NAME:	
	☐ Property Owner ☐ Authorized Agent
MAILING ADDRESS: (STREET ADDRESS, CITY, STATE, ZIP)	
PHONE:	EMAIL:
( )	

1. I am the owner or authorized agent of the owner of this property.
2. The information presented on this application is true and correct to the best of my knowledge.
3. Additional information or applications may be required in order to render this application complete.

Applicant's Signature: _____ Date: _____

PLANNING DEPARTMENT USE ONLY

BLOCK / LOT:	ZONING:	RUD / SUD:	LCU / NCU:

ZONING REFERRAL NUMBER:	OFFICIAL SITE ADDRESS (if different):

BPA NUMBER:	312 NOTICE COMPLETE:	PRELIMINARY SCREENING?
	☐ Yes ☐ No	☐ Yes ☐ No

CASE NO.:	MOTION NO.:	EFFECTIVE DATE:	CONDITIONS:
			☐ Yes ☐ No

OTHER:

ADDITIONAL DOCUMENTS REQUIRED:

☐ SITE PLAN ☐ MASSAGE DOCS ☐ OTHER:

RECOMMENDATION:	Per Planning Code Section:
☐ APPROVAL ☐ DISAPPROVAL	

CONDITIONS OF APPROVAL:

COMMENTS:

AUTHORIZATION:

Signature: _____ Date: _____

Printed Name: _____ Phone: ( ) _____

Restaurant [790.91]: A retail eating and/or drinking use which serves prepared, ready-to-eat cooked foods to customers for consumption on or off the premises and which has seating. It may have a Take-Out Food[790.122] as a minor and incidental use. It may provide on-site alcohol sales for drinking on the premises (ABC Types 41, 47, 49, 59, or 75); however, if it does it is required to operate as a Bona Fide Eating Place[790.142]. It is not required to operate within an enclosed building per Section 703.2(b)(1) so long as it is also a Mobile Food Facility[102.34]. Any outdoor seating and/or dining area is subject to regulation as an Outdoor Activity Area.

Limited Restaurant [790.90]: A retail eating and/or drinking use which serves ready-to-eat foods and/or drinks to customers for consumption on or off the premises, that may or may not have seating. It may provide off-site beer and/or wine sales for consumption off the premises with an ABC Type 20 license within the accessory use limits of Section 703.2(b)(1)(C)(vi).

Bar [790.22]: A retail use which provides on-site alcoholic beverage sales for drinking on the premises. ABC License Types include: 42, 48, or 61 (no minors permitted on premises) and 42 or 60 (minors permitted on premises).

General Grocery [790.102(a)]: A retail food establishment that offers a diverse variety of unrelated, non-complementary food and non-food commodities. May provide beer, wine, and/or liquor sales for consumption off the premises with ABC Type 20 or 21 within the accessory use limits of Section 703.2(b)(1)(C)(vi). May prepare minor amounts or no food on-site for immediate consumption

Specialty Grocery [790.102(b)]: A retail food establishment that offers specialty food products, such as baked goods, pasta, cheese, confections, coffee, meat, seafood, produce, artisanal goods and other specialty food products, and may also offer additional complementory food and non-food commodities. May provide beer, wine, and/or liquor sales for consumption off the premises with ABC Type 20 or 21 within the accessory use limits of Section 703.2(b)(1)(C)(vi). May prepare minor amounts or no food on-site for immediate consumption.

Other may include: Massage Establishment [790.60], **Tobacco Paraphernalia Establishment** [790.123], **Medical Cannabis Dispensary** [790.141], **Service, Personal** [790.116], **Take-out Food** [790.122]

For more information regarding types of establishments, zoning, and Planning Code questions, you may go on-line to www.sfplanning.org or contact the Planning Information Center (PIC) for more information:

Planning Information Center (PIC)
1660 Mission Street, First Floor
San Francisco CA 94103-2479
TEL: **415.558.6377**

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):			
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.

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 CONTACT THE SFPD PERMITS UNIT FOR THE CURRENT BACKGROUND CHECK FEE. SCHEDULE A LIVE SCAN APPOINTMENT BY CALLING 415-553-1115 OR EMAILING SFPDPERMITS@SFGOV.ORG. BRING THIS FORM AND A CHECK OR MONEY ORDER PAYABLE TO SFPD IN PERSON TO SFPD. NO CASH OR CREDIT CARDS ACCEPTED.

49 South Van Ness Avenue, Suite 600, San Francisco, CA 94103
Phone (415) 252-3800, Fax (415) 252-3894