



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)

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.



APPLICATION FOR PERMIT TO OPERATE A MASSAGE ESTABLISHMENT

Date of Application:

Type of Establishment: <input type="checkbox"/> General Massage <input type="checkbox"/> Sole Practitioner		<input type="checkbox"/> OutCall Service		FACILITY ID NO.	
BUSINESS NAME TRADENAME (DBA): ADDRESS:				<input type="checkbox"/> Sole Owner <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation	
				<input type="checkbox"/> New Installation <input type="checkbox"/> Ownership Change <input type="checkbox"/> Reclassification <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please attach a list of each conviction along with the date of the conviction.</i>					
Are you currently pending any investigation regarding any felonies, misdemeanors or lewd conduct <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please attach a list of each conviction along with the date of the conviction.</i>			Have you ever had any massage license or massage establishment licenses denied, suspended or revoked: <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, please attach information about the license denial, revocation or suspension, including dates.</i>		
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 <input type="checkbox"/> N <input type="checkbox"/>	DISTRICT NO.	CENSUS TRACT	PERMIT NO.	TYPE OF PERMIT / CLASSIFICATION
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WRITTEN OPERATIONAL PROCEDURES

Address: _____ **OnSite Mgr:** _____
MANAGER DURING NORMAL WORKING HRS

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

[illegible]

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
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PRACTITIONERS' LIST FOR

DATE: _____

☐ EXISTING ☐ NEW

DBA: _____

Bus. Phone: _____

Address: _____

OnSite Mgr: _____

MANAGER DURING NORMAL WORKING HRS

	FIRST & LAST NAME OF MESSAGE PRACTITIONER <i>Provide copy of current SF Massage Practitioner License Certificate or CAMTC Certificate</i>	PRACT. Check one	PERMIT# (MP)	Office Use ONLY Active?
1)		CAMTC DPH		<input type="checkbox"/> YES <input type="checkbox"/> No Permit
2)		CAMTC DPH		<input type="checkbox"/> YES <input type="checkbox"/> No Permit
3)		CAMTC DPH		<input type="checkbox"/> YES <input type="checkbox"/> No Permit
4)		CAMTC DPH		<input type="checkbox"/> YES <input type="checkbox"/> No Permit
5)		CAMTC DPH		<input type="checkbox"/> YES <input type="checkbox"/> No Permit
6)		CAMTC DPH		<input type="checkbox"/> YES <input type="checkbox"/> No Permit
7)		CAMTC DPH		<input type="checkbox"/> YES <input type="checkbox"/> No Permit
8)		CAMTC DPH		<input type="checkbox"/> YES <input type="checkbox"/> No Permit
9)		CAMTC DPH		<input type="checkbox"/> YES <input type="checkbox"/> No Permit
10)		CAMTC DPH		<input type="checkbox"/> YES <input type="checkbox"/> No Permit
11)		CAMTC DPH		<input type="checkbox"/> YES <input type="checkbox"/> No Permit
12)		CAMTC DPH		<input type="checkbox"/> YES <input type="checkbox"/> No Permit

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



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

By filling out this form, I acknowledge that I am required to schedule and pass a Fire Clearance inspection with SFFD, and will contact SFFD to schedule and pay for the inspection, at (415) 554-8927.

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: _____

HEALTH DEPARTMENT USE ONLY

Date Application Filed:		Health District:	3 4 5	Message	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
 1390 Market Street, Suite 210, San Francisco, CA 94102 - (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? <input type="checkbox"/> Yes <input type="checkbox"/> No	OUTDOOR FOOD/DRINK SERVICE? <input type="checkbox"/> Yes <input type="checkbox"/> No
WHAT FLOOR OF THE BUILDING WILL THE BUSINESS OCCUPY? <input type="checkbox"/> Ground (First) Level <input type="checkbox"/> Second Level <input type="checkbox"/> Third Level <input type="checkbox"/> Other Level:		
1a. Change of Use (depending of the zoning of the property, neighborhood notification may be required): <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the existing use? _____		
1b. Change of business ownership? <input type="checkbox"/> Yes <input type="checkbox"/> No If not a change of ownership, then is it a new establishment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
1c. Is the establishment vacant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long was the establishment vacant? _____		
1d. Do you propose to alter the interior or exterior of the establishment? <input type="checkbox"/> Yes <input type="checkbox"/> 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.? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, a Formula Retail Affidavit is required . (Formula Retail - P.C. Sec. 301.1)		
1f. Does this business sell alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, read page two for category restrictions.		

2. Type of Operation, please check:

<input type="checkbox"/> Restaurant	<input type="checkbox"/> Limited Restaurant
<input type="checkbox"/> Bar	<input type="checkbox"/> General / Specialty Grocery
<input type="checkbox"/> Catering	<input type="checkbox"/> Cottage Food Operator
<input type="checkbox"/> Massage (if applicable, please select your type of massage business below)	
<input type="checkbox"/> Chair/Foot Massage Only	<input type="checkbox"/> Sole Practitioner Establishment
<input type="checkbox"/> Within a gym, hotel, or hospital	
<input type="checkbox"/> Other:	
2a. Accessory Use (business within another business)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, plans are required.	
2b. Days / Hours of Operation: _____	

3. Applicant's Affidavit

NAME:	
<input type="checkbox"/> Property Owner <input type="checkbox"/> Authorized Agent	
MAILING ADDRESS: (STREET ADDRESS, CITY, STATE, ZIP)	
PHONE:	EMAIL:
()	

- I am the owner or authorized agent of the owner of this property.
- The information presented on this application is true and correct to the best of my knowledge.
- 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?
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
CASE NO.:	MOTION NO.:	EFFECTIVE DATE:	CONDITIONS:
			<input type="checkbox"/> Yes <input type="checkbox"/> No
OTHER:			
ADDITIONAL DOCUMENTS REQUIRED:			
<input type="checkbox"/> SITE PLAN	<input type="checkbox"/> MESSAGE DOCS	<input type="checkbox"/> OTHER: _____	

RECOMMENDATION:	Per Planning Code Section:
<input type="checkbox"/> APPROVAL <input type="checkbox"/> 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 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.

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 Section
850 Bryant Street, Room 505
San Francisco, CA 94103
Phone: (415) 553-1115

Monday to Friday 9 AM - 12 PM and 1 PM - 4 PM

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: _____

**SFPD CHARGES \$186.00 FOR BACKGROUND CHECK. APPLICANT NEEDS TO BE PRESENT.
SUBMIT THIS FORM AND PAYMENT IN PERSON TO SFPD. CHECKS OR MONEY ORDER ONLY.
NO CASH or CREDIT CARD.**