Commonwealth of Virginia
Chesapeake Health Department
Division of Environmental Health
748 North Battlefield Boulevard
Chesapeake, VA 23320
(757) 382-8672 Fax (757) 382-8713

Office Records
Date Received _____
$40 Plan Review _____
$40 Annual Permit _____

MASSAGE THERAPY ESTABLISHMENT PERMITAPPLICATION

THIS IS NOT A PERMIT TO OPERATE

Please print or type the information requested below and return the completed application, a copy of your business license (if applicable), and permit fee of $40 to the address listed above. The establishment and owner's name must be the same as recorded on the City of Chesapeake business license. Please note that permits are not transferable in a Change-of-Ownership.

For new establishments: an application with plan review fee of $40 must be submitted to the Chesapeake Health Department for review and approval before any work may be done in the facility. If any existing equipment is to be replaced or new equipment is installed, the manufacturer's specifications must also be submitted. Please contact our office at (757)-382-8672 for more information.

□ New Establishment □ Renewal □ Name Change □ Change of Owner
Business license ONLY required with applications for New Establishments; Name Change; Change of Ownership

Name of Establishment: _____
Facility Address: _____ Suite # _____
Facility Phone: _____ Fax number: _____
Billing Address: _____

Email Address: _____
(Important for Product Recalls & Public Health Emergencies)

Water Supply: **(check appropriate box)** □ Public- Name _____ or □ Private- Type _____
Sewage: **(check appropriate box)** □ Public- Name _____ or □ Private- Type _____

Hours of Operation: Sun _____ Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____
Months of Operation: **Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec**

Name of Owner: _____
Mailing Address: _____
Telephone: _____

Establishment owner is a/an: □ Association □ Corporation □ Individual □ Partnership □ Other Legal Entity

Association, Corporation, Partnership name: _____

Names, titles & addresses of persons comprising the legal ownership (Attach list if necessary):

_____

Person directly responsible for the establishment:

Name_____
Title_____
Address_____
Telephone Number: _____

Immediate supervisor of person directly responsible for the establishment:
Name_____
Title_____
Address_____
Telephone_____

Practitioner List

Practitioner Name	Credentials	Status
	☐ Proof of general physical examination ☐ TB risk assessment ☐ Board of Nursing certification	☐ Owner/practitioner ☐ Contractor ☐ Employee
	☐ Proof of general physical examination ☐ TB risk assessment ☐ Board of Nursing certification	☐ Owner/practitioner ☐ Contractor ☐ Employee
	☐ Proof of general physical examination ☐ TB risk assessment ☐ Board of Nursing certification	☐ Owner/practitioner ☐ Contractor ☐ Employee
	☐ Proof of general physical examination ☐ TB risk assessment ☐ Board of Nursing certification	☐ Owner/practitioner ☐ Contractor ☐ Employee
	☐ Proof of general physical examination ☐ TB risk assessment ☐ Board of Nursing certification	☐ Owner/practitioner ☐ Contractor ☐ Employee
	☐ Proof of general physical examination ☐ TB risk assessment ☐ Board of Nursing certification	☐ Owner/practitioner ☐ Contractor ☐ Employee

I/we attest to the accuracy of the information provided, affirm to comply with the City of Chesapeake Code of Ordinances Chapter 38 and allow the regulatory authority access to the establishment at any reasonable time to inspect, conduct tests or collect samples as required.

Applicant's Signature: ______________________________________ Title: ________________________________

Applicant's Name (printed): _____________________________________ Date: ________________________________

For Official Use:

Census Tract: _________________ Environmental Health Spec.___________________________________

Issue Date: ___________________ Expiration Date: ____