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: _____

Massage Therapy Establishment Plan Review Application

**** Please fill out application entirely. ****

Application Fee $40; Make checks payable to *Chesapeake Health Department*.

Purpose: □ New Establishment □ Renovation □ Name Change □ Owner/Corporation Change

Name of Establishment: _____
Facility Address: _____ Suite # _____
Facility Phone: _____ Email address: _____
Billing Address: _____

Name of Owner_____
Mailing Address: _____
Telephone: _____

Contact Person & Title (architect, manager, builder, etc.): _____
Mailing address: _____
Telephone: _____

I have submitted plans/applications to the authorities on the following dates:

_____ Development & Permits	_____ Commissioner of Revenue	_____ Zoning

Projected Date for Completion of Project: _____

Number of Stations: _____ **Type of Services**: _____
(i.e. reflexology, hand stone, deep tissue, etc.)

Checklist of required documents:

_____ Board of Nursing license, physician letter, and TB test/risk assessment documentation for all practitioners/technicians	_____ Site plans showing location of business in building: location of building on site including location of any outside equipment.
_____ Architectural plans drawn to scale of establishment showing location of equipment, plumbing, electrical services (including lighting), mechanical ventilation and room finishes.	_____ Manufacturer specification sheets for each piece of equipment shown on the plan

FACILITY REVIEW (circle or enter your answer where applicable)

1. Are dressing areas separated by dividers, curtains, or partitions? **YES/NO**
2. Is each patron provided with adequate dressing space? **YES/NO**
3. Are there at least 20-foot candles (Fc) of light provided in each working/operator area? **YES/NO**
4. Are all rooms equipped with adequate ventilation? **YES/NO**
5. Is refuse stored in suitable airtight containers with lids? **YES/NO**
6. Are bathtubs provided for patron use? **YES/NO**
7. Are steam rooms provided for patron use? **YES/NO**
8. Where will janitorial equipment, supplies and storage space be located? _____

WATER SUPPLY

1. Is the facility's water supply public or private? _____
   If private, has the source been approved? **YES/NO**

SEWAGE DISPOSAL

1. Is the building connected to city sewer? _____
   If no is the private disposal system approved? **YES/NO**

SANITATION

1. Describe how unused liquids, single use implements, and other contaminated item(s) will be managed and disposed.
   _____
   _____
   _____
2. How will non-disposable equipment be cleaned and sanitized after each patron?
   _____
   _____
3. How will linens be laundered? _____
4. Where will soiled linens be stored? _____

HANDWASHING/TOILET FACILITIES

1. Number of hand sinks: _____
2. Is there a hand sink in each toilet room? **YES/NO**
3. Do all hand sinks, have a mixing valve or combination faucet allowing hot and cold water? **YES/NO**
4. Are hot and cold, running water under pressure, available at each hand sink with, hot water reading at least 100° F? **YES/NO**
5. Is hand soap available at all hand sinks? **YES/NO**
6. Are disposable paper towels available at all hand sinks? **YES/NO**
7. Are covered waste receptacles available in all operator areas and restrooms? **YES/NO**
8. Are all toilet room doors self-closing? **YES/NO**

****

Approval of these plans and specifications by the Chesapeake Health Department <u>does not</u> indicate compliance with any other code, law or regulation that may be required—federal, state, or local. It further does not constitute endorsement or acceptance of the completed establishment (structure or equipment). A pre-opening inspection of the establishment with equipment in place & operational will be necessary to determine if it complies with the local and state laws governing massage therapy establishments.

STATEMENT: I hereby certify that the above information is correct, and I fully understand that any deviation from the above without prior permission from the Chesapeake Health Department may nullify final approval.

Applicant's Signature: _____ Title: _____
Applicant's Name (printed): _____ Date: _____

****

For Official Use: Items Submitted in Packet

____ Plan review fee of $40

____ Permit application with $40 fee

____ Manufacturer specifications for equipment

____ Plans drawn to scale

____ Practitioner/technician documentation

Make checks payable to:
Chesapeake Health Department or CHD
748 Battlefield Boulevard, North
Chesapeake, VA 23320

Plans Reviewed and Approved EHS: _____ Date: _____

EHS: _____ Date: _____