



LAFAYETTE POLICE DEPARTMENT  
MESSAGE ESTABLISHMENT CERTIFICATE APPLICATION  
(NON-CAMTC CERTIFIED OWNER)  
Lafayette Municipal Code Chapter 4-5

Massage Establishment Application for *Non-California* Massage  
Therapy Council (CAMTC) Certified Owner

Please use this checklist to make sure you meet all the requirements of the Lafayette Municipal Code Chapter 4-5, before scheduling an appointment to avoid unnecessary delays in processing your application. Bring these documents with you.

- Possess an official government ID that proves that the applicant is over the age of 18 (CA driver license, ID Card or other state issued driver license or ID care, passport)
  
- Completed Lafayette Massage Establishment Permit Application.
  
- Permit Fee-fingerprinting. The fee for a massage establishment permit fingerprint and state background check is \$25.00 for Lafayette Resident or \$35.00 for non-Lafayette Resident plus \$32.00 Department of Justice processing fee. You must be fingerprinted and process your application by the Lafayette Police Department. Complete the "Request for Livescan Service Application" at the back of this packet. After completing the application, print it out and bring it with you to your appointment.
  
- Make an appointment for a Livescan-Fingerprint at 925-299-3236 at the Lafayette Police Department. Turn in your application at the time of Livescan-Fingerprint appointment. A photo will be taken at this time.



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<b>DATE:</b>	<input type="checkbox"/> NEW APPLICATION	<input type="checkbox"/> RENEWAL
<i>If approved, Certificate No. _____</i>		

**PROPOSED BUSINESS**

FULL NAME	BUSINESS PHONE ( )
ADDRESS	
TYPE OF ESTABLISHMENT: (massage parlor, spa, sports facility etc.):	
NATURE OR TYPE OF MASSAGE OR BODYWORK TO BE PROVIDED:	
NUMBER OF PEROPLE WHO WILL WORK AS MASSAGE THERAPISTS AND EMPLOYEES:	

**APPLICANT IDENTIFYING INFORMATION**

**“Owner” or “Operator” means any and all owners of a massage business including, without limitation, any of the following persons: a managing officer/employee, a general partner, a limited partner, a shareholder, a sole proprietor, or any person who has a five percent (5%) or greater ownership interest in a massage business whether as an individual, corporate entity, limited partner, shareholder, sole proprietor or otherwise.**

NAME (last, first, middle)	BIRTHDATE:
HOME ADDRESS:	TELEPHONE ( )
CURRENT BUSINESS ADDRESS:	TELEPHONE ( )

**CAMTC CERTIFIED MASSAGE THERAPISTS WORKING AT ESTABLISHMENT  
(ROSTER-EMPLOYEE LIST)**

1. Name:	CAMTC Certificate Number:
2. Name:	CAMTC Certificate Number:
3. Name:	CAMTC Certificate Number:
4. Name:	CAMTC Certificate Number:
5. Name:	CAMTC Certificate Number:
6. Name:	CAMTC Certificate Number:
7. Name:	CAMTC Certificate Number:
8. Name:	CAMTC Certificate Number:

Must update above roster when adding or deleting employees.





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**Other identification and documents.**

*The applicant will be asked to provide all of the following:*

- a. Official, government-issued identification showing the applicant is over 18 years old.
- b. Fingerprints will be taken by the Police Department.
- c. A recent portrait photograph of the applicant. (Taken at the Lafayette Police Department)
- d. Other identification and information that the Chief of Police considers necessary.
- e. Permit application fee.

**Please answer each of the following questions, and explain any YES answers.**

- a. Have you had a massage establishment or similar business permit revoked or suspended in another city or state? If yes, state the reasons below:  Yes  No
- b. Have you ever been convicted of a crime (including a plea of nolo contendere)? If so, state below the nature of the crime and the penalty imposed.  Yes  No
- c. Is there a criminal matter now pending against you?  Yes  No

Explanations:

**Total number of pages in this application, including attachments:**

Please attach:

- Any additional pages needed to complete this application
- Required information regarding each partner, director, officer, managing employee and stockholder.
- Required information regarding each massage therapist and employee.

**Statement and signature of applicant.**

**I have read and understood Lafayette Municipal Code Chapter 4-5 (Massage Establishments) including section 4-513 Revocation or suspension of certificate of registration, and I agree to abide by the regulations in Chapter 4-5.**

**I have no knowingly made any false, misleading or fraudulent statements in this application. As far as I know, no one associated with the massage establishment had made any false, misleading or fraudulent statements in their application to the City.**

**Signature of applicant:** \_\_\_\_\_

**Date:** \_\_\_\_\_

REQUEST FOR LIVE SCAN SERVICE  
Applicant Submission

ORI: A1248 Code assigned by DOJ Type of Application: MASSAGE ESTABLISHMENT  
Job Title or Type of License, Certification or Permit: MASSAGE ESTABLISHMENT CERTIFICATE

Agency Address Set Contributing Agency:  
CITY OF LAFAYETTE 00122  
Agency authorized to receive criminal history information Mail Code (five digit code assigned by DOJ)  
3675 MT. DIABLO BLVD #210 TRACY ROBINSON  
Street No. Street or PO Box Contact Name (Mandatory for all school submissions)  
LAFAYETTE CA 94549 (925) 284-1968  
City State Zip Code Contact Telephone No.

Name of Applicant: \_\_\_\_\_  
(Please print) Last First MI  
Alias: \_\_\_\_\_ Driver's License No. \_\_\_\_\_  
Last First  
Date of Birth: \_\_\_\_\_ Sex:  Male  Female Misc. No. BIL - 141396  
Agency Billing Number  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Misc. No. \_\_\_\_\_  
Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Home Address: \_\_\_\_\_  
Street or PO Box  
Place of Birth: \_\_\_\_\_  
City, State and Zip Code  
SOC: \_\_\_\_\_

Your Number: \_\_\_\_\_  
OCA No. (Agency Identifying No.)  
Level of Service  DOJ  FBI  
If resubmission, list Original ATI No. \_\_\_\_\_

Employer: (Additional response for agencies specified by statute)  
Employer Name \_\_\_\_\_  
Street No. Street or PO Box Mail Code (five digit code assigned by DOJ)  
City State Zip Code ( )  
Agency Telephone No. (optional)

Live Scan Transaction Completed By: \_\_\_\_\_ Date: \_\_\_\_\_  
Name of Operator  
Transmitting Agency ATI No. Amount Collected / Billed