

Licensee: \_\_\_\_\_

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

License# \_\_\_\_\_

**Township of Cedar Grove Health Department**  
**525 Pompton Avenue, Cedar Grove, NJ 07009**  
**Phone# (973)239-1410 x224 ❖ Fax # (973)239-4187**

**Fact Sheet:**

Owner  Massage Practitioner  Other Employee(define) \_\_\_\_\_

<b>Name:</b>	<b>Male    Female</b>			
<b>Residence Address:</b>				
<b>Address</b>		<b>City</b>	<b>State</b>	<b>Zip</b>
<b>Phone:</b>	<b>Home#:</b>	<b>Emergency#:</b>		

**Previous Addresses:**

<b>Address 1:</b>	<b>Dates of residence:</b>	
<b>City</b>	<b>State</b>	<b>Zip</b>

<b>Address 2:</b>	<b>Dates of residence:</b>	
<b>City</b>	<b>State</b>	<b>Zip</b>

**Physical Characteristics:**

<b>Height:</b>		<b>Hair Color:</b>		<b>Age:</b>	
<b>Weight:</b>		<b>Eye Color:</b>		<b>Date of Birth:</b>	

**Previous Massage / Business Experience / History:**

<b>Date Licensed:</b>	<b>Date License expires:</b>
Please attach additional information separately	

**Additional Attachments:**

- |   |   |
|---|---|
| <input type="checkbox"/> Message Certification  | <input type="checkbox"/> Photo ID                           |
| <input type="checkbox"/> 2 Photos               | <input type="checkbox"/> Physician Statement                |
| <input type="checkbox"/> 3 Character References | <input type="checkbox"/> Background check w/ fingerprinting |

I, \_\_\_\_\_ herby declare, under penalty of perjury, that the foregoing information contained and attached to this application is true & correct. I also grant authorization for the Township and it's agents & employees to seek information and conduct and investigation into the truth of the statements set forth in the application and qualifications of the applicant for the permit.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date