CITY OF SOUTH MILWAUKEE
2424 15TH AVENUE
SOUTH MILWAUKEE, WI 53172

OFFICAL OFFICE USE	
Date Received:	
Date to PD:	
Date to CC:	
License # Issued:	

MASSAGE ESTABLISHMENT APPLICATION - $150.00

The undersigned hereby makes application for a license to engage and carry on the business of massage establishment in the city of South Milwaukee from July 1, 20____ until June 30, 20 ____ in pursuance of the provisions of Section 20.12 of the South Milwaukee Municipal Code.

ESTABLISHMENT INFORMATION

Name of Establishment: _____ County: Milwaukee

Location of Establishment: _____

City: _____ State: _____ Zip Code: _____

OWNER/OPERATOR INFORMATION

Name of Operator of Establishment _____ Date of Birth: _____

Home Address of Operator:* _____

*Written Proof Required - Show Driver's License, Birth Certificate, Passport, or other vaild form of identification.

Telephone Number: _____ Email Address: _____

State of Wisconsin License Number (attach copy): _____

PERSONAL DATA - OPERATOR

Height: _____ Weight: _____ Color of Hair: _____ Color of Eyes: _____

Social Security Number: _____

Date you wish to be licensed to open for business? _____

Has this establishment been previously licensed?

☐ No ☐ Yes, Give the **Name** of the former operator and the name of the establishment.

Former Operator: _____ Name of Establishment: _____

License Number _____

Has this applicant or operator ever had a massage establishment license suspended or revoked?

☐ No ☐ Yes, Give the **Reason** and the business entity or trade name under which the applicant operated that was subject to the suspension or revocation:

Indicate here all phone numbers at the proposed establishment:

Main Phone Number: _____ Additional Phone Number(s): _____

_____

_____

If a corporation submits this application - indicate the name and address of each officer including the extent of ownership of each. Indicate whether any of the individuals listed below are officers of OR hold stock in another corporation conducting a similar business in the State of Wisconsin.

OFFICER(S)/DIRECTOR(S) INFORMATION

1 Name: _____ Percentage of Ownership: _____

Address: _____

City: _____ State: _____ Zip: _____

Stock in Similar Wisconsin Business? ☐ Yes ☐ No

2 Name: _____ Percentage of Ownership: _____

Address: _____

City: _____ State: _____ Zip: _____

Stock in Similar Wisconsin Business? ☐ Yes ☐ No

3 Name: _____ Percentage of Ownership: _____

Address: _____

City: _____ State: _____ Zip: _____

Stock in Similar Wisconsin Business? ☐ Yes ☐ No

4 Name: _____ Percentage of Ownership: _____

Address: _____

City: _____ State: _____ Zip: _____

Stock in Similar Wisconsin Business? ☐ Yes ☐ No

(If more space is required, please attach an additional page.)

If Business is a Partnership, list ALL Partners or Limited Partners.

1 Name: _____ Percentage of Ownership: _____

Address: _____

City: _____ State: _____ Zip: _____

Stock in Similar Wisconsin Business? ☐ Yes ☐ No

2 Name: _____ Percentage of Ownership: _____

Address: _____

City: _____ State: _____ Zip: _____

Stock in Similar Wisconsin Business? ☐ Yes ☐ No

3 Name: _____ Percentage of Ownership: _____

Address: _____

City: _____ State: _____ Zip: _____

Stock in Similar Wisconsin Business? ☐ Yes ☐ No

Massage Therapist Employee Information

Names, addresses, and phone numbers of all persons employed as massage therapists by the operator at the proposed establishment on the date of this application: (If more space is required, please attach an additional page.)

1 Name _____ DOB: _____

Address: _____

Telephone Number: _____ Email: _____

Social Security Number: _____ State of WI License #: _____

Color of Hair: _____ Color of Eyes: _____ Height: _____ Weight: _____

2 Name: _____ DOB: _____

Address: _____

Telephone Number: _____ Email: _____

Social Security Number: _____ State of WI License #: _____

Color of Hair: _____ Color of Eyes: _____ Height: _____ Weight: _____

3 Name: _____ DOB: _____

Address: _____

Telephone Number: _____ Email: _____

Social Security Number: _____ State of WI License #: _____

Color of Hair: _____ Color of Eyes: _____ Height: _____ Weight: _____

Number of Non-Masseuse Employees: _____

Names of all persons employed as non-masseuse employees employed by the operator at the proposed establishment on the date of this application:

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

The applicant certifies that the premises are in compliance with the City of South Milwaukee Municipal Code and all building, fire, and health codes and regulations of the City of South Milwaukee. Compliance with such codes and the standards established shall be conditions precedent to the opening of business.

I intend to employ _____ number of massage therapist employees.

The Operator/Applicant's Signature here indicates that the information he/she has provided on or with this application is true and correct.

THE OPERATOR/APPLICANT AGREES AND UNDERSTANDS THAT BEFORE ANY MASSAGE THERAPIST CAN ENGAGE IN MASSAGE OR BODY WORK THAT OPERATOR MUST PROVIDE THE FOLLOWING INFORMATION, AS WELL AS A COPY OF THE MASSAGE THERAPIST EMPLOYEE STATE OF WISCONSIN LICENSE.

Operator/Applicant Signature

Dated

All members of this business partnership or joint venture must sign below, thereby indicating their agreement that the information provided on or with this application is true and correct.

Signature

Print Name

Signature

Print Name

Signature

Print Name

Signature

Print Name