

**TOWN OF NORTH ANDOVER**  
**Office of COMMUNITY DEVELOPMENT AND SERVICES**  
**HEALTH DEPARTMENT**  
**1600 OSGOOD STREET; BUILDING 20; SUITE 2-36**  
**NORTH ANDOVER, MASSACHUSETTS 01845**



Susan Y. Sawyer, REHS/RS  
Public Health Director

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<http://www.townofnorthandover.com>

**APPLICATION FOR LICENSE TO PRACTICE MASSAGE THERAPY**

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

Name: \_\_\_\_\_

DBA: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone#: \_\_\_\_\_

E-Mail: \_\_\_\_\_

To Practice Massage Therapy at: \_\_\_\_\_  
(Name of Licensed Massage Establishment you will practice at)

Location of Business: \_\_\_\_\_

Telephone# of Business: \_\_\_\_\_

Hours of Operations: \_\_\_\_\_

SS# or Federal ID#: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

**Note: You are required to notify the Health Department in writing if you move to another Massage Therapy Establishment in North Andover, or if you leave the business.**

**Fee: \$70.00** Please make check payable to: Town of North Andover  
Late fee after January 1<sup>st</sup> will double the cost - \$140.00

## CHECKLIST FOR MASSAGE THERAPIST

### **Minimum Requirements:**

- \_\_\_\_\_ **Age (21) or older**
- \_\_\_\_\_ **High School Graduate**
- \_\_\_\_\_ **Working at Approved Establishment**

### **Educational Info:**

- \_\_\_\_\_ **Location and Name of School**
- \_\_\_\_\_ **Diploma / Graduation Certification**
- \_\_\_\_\_ **Outline of Courses**

### **Medical:**

- \_\_\_\_\_ **Physical Exam (*within 45 days prior to application*)**
- \_\_\_\_\_ **Chest X Rays (*within 45 days prior to application*)**

### **Notes:**