

**ARKANSAS DEPARTMENT OF HEALTH
COSMETOLOGY AND MASSAGE THERAPY SECTION
4815 West Markham, Slot 8
Little Rock, AR 72205
(501) 682-2168 (501) 683-1448**

MASSAGE THERAPY SPA/CLINIC REGISTRATION

INSTRUCTIONS: File this application when registering for a new spa/clinic certificate. You will receive a certificate of authorization, to be posted in the reception area, which will allow operate said spa/clinic.

If requested information is not applicable, please respond with N/A

Spa/Clinic Name					Telephone Number		
Address Where Spa/Clinic Receives Mail			Suite #	City	County	State	Zip Code
Physical Address of Spa/Clinic			Suite #	City	County	State	Zip Code
Type of Spa/Clinic (CHECK ONE) <input type="checkbox"/> COSMETOLOGY <input type="checkbox"/> MANICURE <input type="checkbox"/> ELECTROLOGY <input type="checkbox"/> AESTHETICIAN <input type="checkbox"/> MASSAGE					Email Address		
Days Open (Check all that apply) <input type="checkbox"/> Sunday <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday						Opening Date	

Owner Information

Is the owner a Corporation? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of corporation:	If no, is owner licensed? <input type="checkbox"/> Yes <input type="checkbox"/> No	License Number
---	------------------------------	---	----------------

Complete the following information regarding the owner

Last Name		First Name			Middle Name		
SSN	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Race <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Am. Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian <input type="checkbox"/> Alaskan Native				
Owner or Corporation Address		Apt. #	City	County	State	Zip Code	
Owner or Corporation Email address				Owner or Corporation Phone Number			

Applicant Signature: By signing this registration, I certify that the information provided is correct to the best of my knowledge, and I am the spa/clinic owner or am authorized to act as the owner's agent. Further, I understand that false statements will be sufficient grounds for the Massage Therapy Technical Advisory Committee to take disciplinary action. I have read this form, the laws and the rules and have complied with them during this process. In addition, I agree to close the spa/clinic in the event that the Inspector determines that the spa/clinic is not in compliance with the applicable laws and rules.

Owner's Signature	Today's Date
-------------------	--------------

DO NOT WRITE BELOW THIS AREA – FOR OFFICE USE ONLY

LICENSE NUMBER	RECEIPT NUMBER	DATE