



MESSAGE ESTABLISHMENT REACTIVATION APPLICATION

Mail to: Tennessee Department of Health
Health Related Boards
227 French Landing, Suite 300
Heritage Place MetroCenter
Nashville, TN 37243
615-253-2111
www.state.tn.us/health

License No.: _____

Name of Massage Establishment _____

Previous Name(s): _____

Complete Present Address: _____

(City, State, Zip Code) _____ Telephone: () _____

Name of Owner: _____

Address: (If different than above) _____

_____ Telephone: () _____

Reason(s) for Reinstatement: _____

Name and license number of all massage therapists practicing in establishment (attach a copy of each therapist(s) renewal certificate, attach separate sheet of paper if necessary).

_____, _____, _____

List dates of establishment operation that required owner to hold a current Tennessee establishment license:

Beginning Date: _____ Ending Date: _____

- 1. Have you (owner) been convicted of any crime and not notified the Board? Yes No
- 2. Has any health professional license you hold ever been disciplined? Yes No
- 3. Are you (owner) currently in good physical and mental health? Yes No

State of _____, County of _____, _____

has appeared before me and, being duly sworn, states that the information given in this application is strictly true on this _____ day of _____, _____.

Seal

Legal Signature of Applicant

Notary's Name

My Commission Expires _____