

HUDSON BOARD OF HEALTH

78 Main Street, Hudson, Massachusetts 01749 Phone (978) 562-2020 Fax (978) 562-8508

APPLICATION FOR LICENSE

Date:

To the Town of Hudson Licensing Authorities:

The undersigned hereby applies for a License in accordance with the provision of the Statute relating thereto:

Print Full Name (APPLICANT)

PURPOSE FOR WHICH LICENSE IS REQUESTED:

TO ENGAGE IN THE PRACTICE OF BODYWORK ACCORDING TO THE RULES AND REGULATIONS OF THE TOWN OF HUDSON

Complete Name of Establishment and Location by Street and Number in the Town of Hudson:

Establishment

Location

Telephone Number(s) of the Establishment:

I certify under the penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid all state taxes required under the law.

Signature of Individual or Corporate Name (Mandatory)

Corporate Officer (Mandatory)

SSN or Federal ID #

THIS LICENSE WILL NOT BE ISSUED UNLESS THIS CERTIFICATION CLAUSE IS SIGNED BY APPLICANT

Your Social Security Number (SSN) will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licenses who fail to correct their non-filing or delinquency will be subject to the License suspension or revocation. This request is made under the authority of M.G.L. c.62C, § 49A.

Signature of Applicant	Print Full Name
Telephone No.	Mailing Address (if different than above)
Cellphone No.	E-Mail Address

Applicant 24-Hour Emergency Phone No.

Applicant Name: _____

Date

List Complete Name and Location of Establishment(s) at which you are currently employed:

Print

Establishment Name	Establishment Address

Please answer the following questions:

Have you ever had a revocation, restriction or den	ial of	a permit	or license to practice bodywork issued by any state
or municipality or jurisdiction for any reason:		No	□ Yes (if so, attach disclosure*)

Have you ever had a revocation, restriction or denial of a certificate issued by *any* jurisdiction or certification body:

Applicant is at least 21 (twenty-one) years of age or older:	Yes	□ No
Applicant can communicate effectively in English:	Yes	🗆 No

I allow one front faced digital photograph to be taken by the Hudson Health Department at the time of this license application's submission to be attached to the license, if granted. \Box Yes \Box No

Documents to be attached to this Application for Individual Bodywork Therapist:

\Box Non-refundable application fee of \$100	Copy of High School Diploma or equivalent
□ Copies of two (2) forms of satisfactory identification	Massachusetts Physician's Letter, on its official
Complete CORI/SORI Request Form	letterhead, dated no earlier than six months prior to
	submittal of this application
□ If applicable, disclosures as specified above*	□ Two (2) original letters from health care professionals
	attesting to personal character and professional ethics
□ Copy of professional certification(s)	□ A signed passport type photo taken within last 30 days

THE TOWN OF HUDSON BOARD OF HEALTH RULES AND REGULATIONS GOVERNING THE PRACTICE OF BODYWORK, AS PROMULGATED BY THE BOARD OF HEALTH, PURSUANT TO ITS AUTHORITY UNDER M.G.L. CHAPTER 111, SECTION 31, HAS BEEN PROVIDED TO APPLICANT WITH THIS APPLICATION BY THE TOWN OF HUDSON HEALTH DEPARTMENT.

ACKNOWLEDGMENT

I have read and agree to abide by the Hudson Board of Health Rules and Regulations Governing the Practice of Bodywork (Regulation 17-1), copy of which has been furnished to me. By signing this application, I declare, under the penalty of perjury, that the forgoing information contained in this application is true and correct. False statements shall constitute grounds for revocation, suspension, or denial of an issued or un-issued license.

By signing this acknowledgment, I authorize the Town of Hudson, its agents, and employees to seek information and to conduct an investigation into the truth of the statements set forth in this application which shall include both a Criminal Offender Records Information and a Sexual Offender Records information request with the Criminal System History Board.

By signing this application, I understand that establishments and therapists are subject to inspections, as specified in the Regulations, by the Department or its authorized agent(s) during all times of operation. I understand the failure to abide by these Regulations may result in revocation of my license to practice bodywork.

Signature of Applicant