Town of Southborough
Health Department
9 Cordaville Road, Lower Level
Southborough, MA 01772-1662

Phone: (508) 481-3013
Fax: (508) 983-7729

2025 Bodywork Therapist Application

Permit Fee due: $100

Therapist Name: _____

Home Address: _____

Email: _____Home Telephone #: _____

Mailing Address: _____

_____

Establishment Name (dba):_____

Owner Name: _____

Email:_____ Business Telephone #:_____

Questionnaire (*Check all applicable boxes*)

Have you been convicted of a felony within the last year?	☐ **Yes**	☐ **No**
Have you been charged with a felony within the last year?	☐ **Yes**	☐ **No**
Have you been convicted of a misdemeanor or a felony within the last year?	☐ **Yes**	☐ **No**
Have you ever had a license to practice massage denied, suspended, or revoked?	☐ **Yes**	☐ **No**
Have you ever received a disciplinary action from the state board?	☐ **Yes**	☐ **No**
Have you ever lost a license or certification by any municipality or other jurisdiction for any reason?	☐ **Yes**	☐ **No**

Please explain the circumstances around the conviction if you answered "yes" to any of the questions.

_____

_____

_____

_____

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I have read and agree to abide by Southborough Board of Health Bodywork Regulation.

It is a violation of Southborough Board of Health Bodywork Regulation for any person who is not licensed in this manner to operate a Bodywork Establishment or as an Individual Bodywork Therapist.

By signing this, I declare under the penalty of perjury, that the foregoing 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 I authorize the Town of Southborough, its agents and employees, to seek information and investigate 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.

Signature: _____ **Date:** _____

REMINDER YOU NEED TO SUBMIT:

Completed Signed Renewal Application	☐
Fee of $100	☐
A recent front-faced color photograph (passport size photo)	☐
Submit two forms of identification (e.g. Driver's License, Passport, etc.)	☐
Completed Physician's Statement or copy of recent physical	☐

REMINDERS:

All permits expire on December 31st. Any individual that does not renew their license will be considered "operating without a license" and subject to penalties and fines. Please contact the Health Department at 508-481-3013 with any questions.

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Individual Bodywork Therapist Release of Medical Information & Physicians' Statement

To be filled out by applicant:

I _____, authorize _____ to release all relevant health
Applicant **Doctor or Physician**
information to the Southborough Health Department for the purpose of applying for a Bodywork Therapy License pursuant to Board of Health Regulations. I certify under the penalty of Perjury, that the information I provided to the medical professional is true and correct. I am aware that the knowing placement of false information on the application or health forms may subject me to civil or criminal penalties. I understand if this form is not completely filled out or I fail to submit any required documentation, I may not be found eligible for an Individual Bodywork Therapist License.

Applicant Signature:_____ Date:_____

To be filled out by physician:

Dear Physician,

Your patient has expressed an interest in obtaining a license to conduct Bodywork Therapy within Southborough, Massachusetts. Board of Health Bodywork Regulations require all applicants to have a physical examination by a licensed physician, to be in good health, to be up-to-date on all required adult immunizations, and free from communicable diseases and/or conditions that may be transmitted due to close physical contact and which may be detrimental to the public's health. Please complete the attached questionnaire located on the next page.

Thank you for completing this form and feel free to call the Southborough Nurse at (508)281-8983 if you have any questions regarding this request. Statements may be submitted to the Health Department via confidential fax at (774) 448-5150.

Respectfully,

Southborough Health Department
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Southborough MA 01772
508-481-3013

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Date:

I am a physician in good standing, licensed in the state of _____.
State of Licensure

_____ is my patient and has been my patient for_____ years.
Applicant **Patient Timeframe**

I have performed a medical examination within the last *six* months and have obtained the following results:

Individual appears to be in good health:		**Yes**	**No**
To your knowledge, does the individual have any communicable diseases and/or conditions that may be transmitted via close physical contact and which may be detrimental to public health?		**Yes**	**No**
TB test administered:		**Yes**	**No**
If yes, negative result achieved:	**N/A**	**Yes**	**No**
Individual is up-to-date with adult immunizations:		**Yes**	**No**
Date of last physical examination:			

These results are based on my knowledge of the patient to date, as well as, the physical examination performed on the date stated above. ***However, the health and/or conditions of the applicant may change at any time in the future.***

Sincerely,

_____, M.D.

State License #: _____
Printed Name of MD: _____
Address: _____
Contact Phone #: _____