



City of Rockford – Customer Service Center
1st floor, City Hall, 425 E. State Street, Rockford, IL 61104
779-348-7300 CustomerService@rockfordil.gov

PERMIT APPLICATION – MASSAGE ESTABLISHMENT

THIS APPLICATION MUST BE ACCOMPANIED BY THE \$50.00 PERMIT FEE, COPY OF STATE OF ILLINOIS LICENSE PERSUANT TO 225 ILCS 57/1 MASSAGE LICENSING ACT OR VALID CERTIFICATE ISSUED BY AN AUTHORIZED BONA FIDE ORGANIZATION AS SET FORTH IN SECTION 25G OF THE ACT AND ALL OTHER REQUIRED DOCUMENTATION AS INDICATED ON ORDINANCE NO. 2017-205-O. APPLICANT MUST BE AT LEAST 18 YEARS OLD AND PROVIDE WRITTEN PROOF OF AGE AND 2” x 2” PORTRAIT (A COPY OF A VALID STATE ID OR DRIVER’S LICENSE SATISFIES THIS REQUIREMENT.)

Name of Applicant: _____ Date of Birth: _____

Applicant Address: _____
Street City/State/Zip

Applicant Phone #: _____ Email Address: _____

Business Name: _____ Tax ID: _____

Business Address: _____
Street City/State/Zip

Applicant is a (check one): ___ Individual ___ Partnership ___ Corporation

If applicant is a corporation: Corporate Name: _____

Date of Incorporation: _____ State of Incorporation: _____ Tax ID: _____

Registered Agent: Name: _____

Address: _____
Street City State Zip

Attach CORPORATE ADDENDUM listing names and addresses of all officers, directors and 10% or more shareholders.

PREVIOUS ADDRESSES PRIOR TO PRESENT ADDRESS OF APPLICANT:

Applicant’s Demographic Information: HEIGHT _____ WEIGHT _____
COLOR OF EYES _____ COLOR OF HAIR _____ OCCUPATION _____

PREVIOUS EMPLOYMENT (PAST 3 YEARS)

HAS THE APPLICANT EVER HAD A BUSINESS LICENSE SUSPENDED OR REVOKED? _____

IF YES, PLEASE EXPLAIN _____

HAS THE APPLICANT EVER BEEN CONVICTED OF A FELONY? _____

IF YES, PLEASE EXPLAIN _____

HAS THE APPLICANT EVER BEEN CONVICTED OF A CRIME? _____

IF YES, PLEASE EXPLAIN _____

IS THE APPLICANT INTENDED TO WORK AS A MASSAGE THERAPIST AT THE ESTABLISHMENT? _____
IF YES, A COPY OF THE MASSAGE THERAPIST LICENSE MUST BE SUBMITTED.

Type of massage (s) offered at establishment: _____

NAME AND ADDRESS (S) OF ALL MASSAGE THERAPIST (S) TO BE EMPLOYED AT THE ESTABLISHMENT INCLUDING ID(S) AND LICENSE (S) OF EACH EMPLOYEE BY THE ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATIONS PURSUANT TO THE MASSAGE LICENSING ACT.

Please note a twenty percent (20%) penalty will be added to the license fee if not paid within 30 days; furthermore, if not paid within sixty (60) days, the penalty will be fifty percent (50%)

I, the undersigned, thoroughly understand that this is solely an application to operate a business, and is not permission to operate a business until all applicable ordinances of the City of Rockford including but not limited to Building and Fire regulations, and the laws of the State of Illinois, have been fully complied with, and this application is properly signed by the departments listed below, and an official license is issued by the Finance Director or designee.

Signature: _____ Date: _____

FOR OFFICE USE ONLY:

Date application received: _____ Received By: _____

License fee attached: YES / NO Final Action due: _____ (21 days from receipt)

Zoning: Approved / Disapproved By: _____ Date: _____

Building: Approved / Disapproved: By: _____ Date: _____

Legal: Approved / Disapproved: By: _____ Date: _____

Mayor's Office: Approved / Disapproved: By: _____ Date: _____

Fire: Approved / Disapproved: By: _____ Date: _____

Finance: Approved / Disapproved: By: _____ Date: _____