



MESSAGE ESTABLISHMENT REACTIVATION APPLICATION

Mail to: Tennessee Department of Health
Health Related Boards
665 Mainstream Drive
Nashville, TN 37243
615-253-2111
<https://www.tn.gov/health/health-professionals.html>

License No.: _____

Fees for Retired License \$145.00
Fees for Expired License \$245.00

Name of Massage Establishment _____

Establishment Previous Name(s): _____

Complete Present Address: _____

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

Name of Owner: _____

Home Address: (If different than above) _____

E-mail Address: _____ 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

If you answer "yes" to questions 1 or 2 above, you must supplement your affirmative response with a thorough explanation on a separate page. In support of your explanation, the final document or orders from the issuing states, courts, and/or agencies must be submitted along with this application. Additional information may be requested and/or required before a licensure decision may be made.

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 _____