



**A RENEWAL LICENCE HAS EFFECT FOR A PERIOD OF ONE YEAR.**

**B. APPLICANT (Sole Trader or Partnership)**

Forenames (in full) and Surname (See Note 1 below)

If more than two applicants please give details on a separate sheet.

Mr/Mrs/Miss:	Date of Birth: / /
Private:	Tel. No:
Post Code:	
Place of Birth:	Nationality:
Qualifications held to give relevant treatments (documentary confirmation will be required).	

Mr/Mrs/Miss:	Date of Birth: / /
Private:	Tel. No:
Post Code:	
Place of Birth:	Nationality:
Qualifications held to give relevant treatments (documentary confirmation will be required).	

**C. APPLICANT (Company, Society etc.)**

Forenames (in full) and Surname(s) of present Director(s) (See Note 1 below). If more than two Directors please give details on a separate sheet.

Mr/Mrs/Miss:	Date of Birth: / /
Private:	Tel. No:
Post Code:	
Place of Birth:	Nationality:
Qualifications held to give relevant treatments (documentary confirmation will be required).	

Mr/Mrs/Miss:	Date of Birth: / /
Private:	Tel. No:
Post Code:	
Place of Birth:	Nationality:
Qualifications held to give relevant treatments (documentary confirmation will be required).	

**NOTE:**

1. In the case of a partnership, the full names of each partner and their respective private addresses must be entered; in the case of a company the name of the company and the address of its principal office.

2. Each partner of a partnership must sign. If the applicant is a company, a director or other authorised person must sign indicating position held.

**NOTE: SECTIONS D AND G MUST BE COMPLETED EVEN IF THERE HAS BEEN NO CHANGE TO THE STAFF OR THE BUILDING SINCE THE TIME OF APPLICATION OR THE LAST DATE OR RENEWAL. INCOMPLETE APPLICATIONS WILL BE RETURNED.**

**D. STAFF WHO WILL CARRY OUT TREATMENTS IF OTHER THAN THE LICENSEE(S):**  
Forenames (in full) and Surname(s)

If more than two staff please give details on a separate sheet.

Mr/Mrs/Miss:	Date of Birth: / /
Private:	Tel. No:
Post Code:	
Place of Birth:	Nationality:
Qualifications held to give relevant treatments (documentary confirmation will be required).	
Previous experience/employments:	

Mr/Mrs/Miss:	Date of Birth: / /
Private:	Tel. No:
Post Code:	
Place of Birth:	Nationality:
Qualifications held to give relevant treatments (documentary confirmation will be required).	
Previous experience/employments:	

**Note: Two identical full – face passport size photographs (taken within the previous 12 months) of all persons who will be giving the treatments must be supplied with this form. Each photograph should be endorsed with the date on which it was taken , bear the name in block capitals of the person whose likeness it bears and be signed by the applicant.**

**E. SERVICES PROVIDED ELSEWHERE**

Does the applicant propose to carry on a visiting massage service either from these premises or elsewhere? ( a )

If elsewhere please state address(es) concerned ( b )

Will the masseuses employed on this service also give treatment on the licensed premises? ( c )

**F. DESCRIPTION OF PREMISES:**

1. Please describe the premises.	
2. Please describe the type of lighting in the in the premises.	
3. How will the premises be heated?	
4. What form of ventilation will be used?	
5. In the case of fire. How do you get out?  (a) the basement (if any) (b) the ground floor (c) the upper floors	
6. Please describe the number and types of Fire Extinguishers & Fire Blankets you have in the premises.	
7. What nights of the week do you want to be Open?	
8. What hours of opening and closing do you Want?	
9. What will be the highest number of people (including staff) on the premises at any one time.	
11. Number of toilets on the premises	



Form Sent:	Elec. Cert. Date:	Valid:	Yrs.	App. No:
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