



TOWN OF UXBRIDGE
Board of Health
21 South Main Street
Uxbridge, Massachusetts 01569
Telephone: (508) 278-8600 Ext.8
boh@uxbridge-ma.gov

REFLEXOLOGY ESTABLISHMENT PERMIT APPLICATION

Date: _____, 20____

Non-Refundable Fee **\$150.00**

(Checks made payable to Town of Uxbridge)

A permit for Reflexology Establishments shall not be transferable from one place or person to another. This requires a new application and license. A satisfactory inspection by the Board of Health is required before the issuance of the Reflexology Establishment permit.

Establishment Name: _____

Establishment Physical Address: _____

Phone: _____

Name of Establishment Owner(s): _____

Address: _____

Phone: _____ Date of Birth: _____

Email Address: _____

**** If there are additional owners, attach additional Name(s), Address(es), Dates of Birth and telephone number(s).**

Person in Charge: _____

24 Hour Emergency Telephone Number(s): _____

Please submit copies of the following with your completed application:

() A copy of the applicants' valid government ID example – state issued driver's license, passport or passport card, state issued ID.

() names and addresses of any other establishments owned by the applicant

() A drawing of the floor plan of the establishment to scale.

() Copy of Certificate of Insurance for Workers' Compensation and Liability with the Uxbridge Board of Health listed as a certificate holder

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STATEMENT: I, _____ hereby certify that the above information is correct and agree to comply with the Uxbridge Board of Health requirements governing the practice of Reflexology. I fully understand that any change from the above without prior permission from the Board of Health and any false information provided in the application shall be grounds for denial or revocation of a permit.

Pursuant to Chapter 62 C, Section 49 A of the Massachusetts General Laws, I certify under the penalties and pains of perjury that I have, to the best of my knowledge and belief, filed all state tax returns and paid all state taxes required under law.

The applicant named above has solemnly affirmed, under the penalties of perjury, that the statements made herein are true.

Applicants Signature

Date

REAP ATTESTATION FORM
Massachusetts Department of Revenue

REVENUE ENFORCEMENT AND PROTECTION (REAP) ATTESTATION

I certify under the penalties of perjury that I, to my best 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)

By: Corporate Officer (Mandatory, if applicable)

**Social Security Number (Voluntary) or Federal Identification Number

*This license will not be issued unless this certification is signed by the applicant.

**Your Social Security number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Massachusetts General Law C. 62C. s. 49A.