

**City of St. Paul Park
600 Portland Avenue
St. Paul Park MN 55071**

Date: _____

The following named individual has made application with the City of St. Paul Park for a Therapeutic Massage Business and/or Massage Therapist license.

Last Name of Applicant (please print): _____

First Name (please print): _____

Middle (full) (please print): _____

Maiden, Alias or Former (please print): _____

Date of Birth: _____ Sex: ___M ___F
Month/Day/Year

Social Security Number (optional): _____

I authorize the Minnesota Bureau of Criminal Apprehension to disclose all criminal history record information to the St. Paul Park Police Department for the purpose of a Therapeutic Massage Business/Massage Therapist license in the City of St. Paul Park.

The expiration of this authorization shall be one year from the date of my signature.

Signature of Applicant: _____ Date: _____