Massage Therapy Program
Application to Relocate Massage Therapy Establishment

Alabama Department of Public Health

For Department Use Only

_____ Date Received
_____ Approved By

Owner Information

Applicant First Name _____ Last Name _____
Mailing Address _____
City _____ State _____ Zip _____
Date of Birth _____ /_____ /_____ Social Security Number _____ - _____ - _____
Alabama Massage Therapist License Number (if applicable) _____

List additional owners, officers, directors, members, or partners of the entity applying as an establishment

Name	Date of Birth	Social Security Number

Establishment Information

Establishment Name _____ dba _____
Establishment Phone _____
Current Street Address _____
City _____ State Alabama Zip _____
Proposed Street Address _____
City _____ State Alabama Zip _____
Name of Entity Possessing Right to Occupy Premises _____
LMT designee to ensure establishment's compliance with state law and all administrative rules
Name _____ License Number _____

Please provide the following along with application:

- ☐ Deed, lease, or other document establishing lawful possession of the new location in the name of the sole proprietor, corporation, limited liability company, or partnership holding the massage therapy establishment license
- ☐ Documentation proving that the establishment either has vacated the prior location or is required to vacate the prior location by a date-certain within sixty (60) days of the request
- ☐ Proof of insurance coverage

I hereby certify that the information contained in this application and the documents appended to this application are true and correct, to the best of my knowledge and belief. I further certify, as the holder of the Alabama Massage Therapy Establishment license, that the massage therapy establishment has physically relocated, without change in the previous name or ownership of the massage therapy establishment. I understand that a successful inspection of the new location is required before my request to relocate my establishment can be authorized.

Signed _____Date_____

Please email completed form and other applicable documentation to Massage.Therapy@adph.state.al.us

Alabama Department of Public Health
Massage Therapy Program
RSA Tower, 201 Monroe Street, Suite 1250
Montgomery, AL 36104
(334) 206-5373

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