ENCLOSE $150 FEE

This form is for reinstating your registration if you have failed to renew it within 45 days of initial registration. **REGISTRATION #**_____
Return to: Missouri Attorney General's Office • Attention: Registration Specialist • P.O. Box 899 • Jefferson City, MO 65102

Health Spa Information

LIST NAME UNDER WHICH HEALTH SPA DOES BUSINESS _____

HEALTH SPA LOCATION _____ Street _____ City _____ State _____ Zip ( ) - _____ Phone

IF THE HEALTH SPA IS SELLING SPA CONTRACTS OR SPA SERVICES ON A PREPAYMENT BASIS STATE:

The date of anticipated first sales of said contracts or health spa services. _____ MM-DD-YYYY The date of anticipated first opening of the health spa. _____ MM-DD-YYYY

IF THE HEALTH SPA IS SELLING SPA CONTRACTS OR SPA SERVICES ON A NON-PREPAYMENT BASIS STATE:

The date of anticipated first sales of said contracts or health spa services. _____ MM-DD-YYYY The date of first opening of the health spa. _____ MM-DD-YYYY

LIST THE ADDRESS AND PHONE NUMBER OF EACH HEALTH SPA IN MISSOURI AFFILIATED WITH THE HEALTH SPA NOW REGISTERING.
(Attach additional pages as necessary and mark as Attachment A.)

PHONE NO. ( ) - ADDRESS _____ Street

_____ City _____ State _____ Zip _____ County

PHONE NO. ( ) - ADDRESS _____ Street

_____ City _____ State _____ Zip _____ County

WHAT TYPE OF BUSINESS ENTITY IS THE HEALTH SPA?

☐ **Corporation** (attach articles of incorporation) ☐ **Sole proprietorship**

☐ **Partnership** (attach partnership agreement) ☐ **Other** (Please explain.) _____

STATE THE DATE THE HEALTH SPA COMMENCED DOING BUSINESS IN ITS PRESENT COUNTY. _____ MM-DD-YYYY

IF THE HEALTH SPA IS A CORPORATION, LIST THE NAME, ADDRESS, POSITION AND TELEPHONE NUMBER OF ALL OFFICERS AND DIRECTORS OF THE CORPORATION.

NAME _____ PHONE NO. ( ) -

ADDRESS _____ Street _____ City _____ State _____ Zip _____ Position

NAME _____ PHONE NO. ( ) -

ADDRESS _____ Street _____ City _____ State _____ Zip _____ Position

NAME _____ PHONE NO. ( ) -

ADDRESS _____ Street _____ City _____ State _____ Zip _____ Position

IF THE HEALTH SPA IS A PARTNERSHIP, LIST THE NAME, ADDRESS AND TELEPHONE NUMBER OF EACH PARTNER.

NAME _____ PHONE NO. ( ) -

ADDRESS _____ _____ _____ _____ _____
Street City State Zip County

NAME _____ PHONE NO. ( ) -

ADDRESS _____ _____ _____ _____ _____
Street City State Zip County

NAME _____ PHONE NO. ( ) -

ADDRESS _____ _____ _____ _____ _____
Street City State Zip County

LIST THE NAME, ADDRESS AND PHONE NUMBER AND INTEREST OWNED BY ANY PERSON WHO OWNS 10% OR MORE INTEREST.

NAME _____ PHONE NO. ( ) -

ADDRESS _____ _____ _____ _____ _____
Street City State Zip Interest

NAME _____ PHONE NO. ( ) -

ADDRESS _____ _____ _____ _____ _____
Street City State Zip Interest

IF THE HEALTH SPA IS A CORPORATION, LIST THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE REGISTERED AGENT.

NAME _____ PHONE NO. ( ) -

ADDRESS _____ _____ _____ _____ _____
Street City State Zip County

LIST THE NAME, ADDRESS AND TELEPHONE NUMBER OF EACH MANAGER OPERATING THE HEALTH SPA.

NAME _____ PHONE NO. ( ) -

ADDRESS _____ _____ _____ _____ _____
Street City State Zip County

NAME _____ PHONE NO. ( ) -

ADDRESS _____ _____ _____ _____ _____
Street City State Zip County

WHAT TYPE OF EQUIPMENT AND PROGRAMS ARE CURRENTLY BEING OFFERED TO MEMBERS OF THE HEALTH SPA?
(Attach additional pages as necessary and mark as Attachment B.)

_____

_____

_____

LIST THE NAME, ADDRESS AND TELEPHONE NUMBER OF ALL BANKS, SAVINGS AND LOAN ASSOCIATIONS AND ALL OTHER SUCH FINANCIAL INSTITUTIONS IN WHICH THE HEALTH SPA MAINTAINS ANY CHECKING, SAVINGS, LOAN OR ANY OTHER ACCOUNT.

NAME _____ PHONE NO. (☐☐☐) ☐☐☐ - ☐☐☐☐

ADDRESS _____ _____ _____ _____ _____
Street City State Zip County

NAME _____ PHONE NO. (☐☐☐) ☐☐☐ - ☐☐☐☐

ADDRESS _____ _____ _____ _____ _____
Street City State Zip County

HAS THE HEALTH SPA OR ANY AGENT OR SUBSIDIARY OF THAT HEALTH SPA EVER BEEN DENIED A LICENSE OR PERMIT TO CONDUCT BUSINESS AS A HEALTH SPA OR HAD ANY SUCH LICENSE OR PERMIT REVOKED? ☐ Yes ☐ No

If the answer above is **YES**, please explain in detail by providing the location of the action, the name of the governmental agency that brought the action, and the date and nature of the action. Attach additional pages as necessary and mark as **ATTACHMENT C**.

_____ _____
LOCATION OF ACTION DATE OF ACTION (MM-DD-YY)

_____
GOVERNMENT AGENCY THAT BROUGHT ACTION

_____
NATURE OF ACTION

HAS THE HEALTH SPA OR ANY AGENT OR SUBSIDIARY OF THAT HEALTH SPA EVER BEEN ENJOINED OR PROHIBITED FROM CONDUCTING BUSINESS AS A HEALTH SPA BY ANY GOVERNMENTAL AGENCY? ☐ Yes ☐ No

If the answer above is **YES**, please explain in detail by providing the location of the action, the name of the governmental agency that brought the action, and the date and nature of the action. Attach additional pages as necessary and mark as **ATTACHMENT D**.

_____ _____
LOCATION OF ACTION DATE OF ACTION (MM-DD-YY)

_____
GOVERNMENT AGENCY THAT BROUGHT ACTION

_____
NATURE OF ACTION

HAVE ANY OF THE OFFICERS, DIRECTORS, MANAGERS OR ANYONE ELSE OWNING MORE THAN 10% OF THE HEALTH SPA EVER BEEN CONVICTED OF A FELONY? ☐ Yes ☐ No

If the answer above is **YES**, please explain in detail. Attach additional pages as necessary and mark as **ATTACHMENT E**.

_____

_____

_____

_____

_____

WHAT IS THE MAXIMUM LENGTH OF THE MEMBERSHIP CURRENTLY BEING OFFERED FOR SALE AND SOLD FOR THE HEALTH SPA?
(Attach copies of all contracts for membership currently being used by the health spa.)

_____

_____

_____

Verification Statement

VERIFICATION

State _____)
County _____) SS.

_____ being duly sworn deposes and states that s/he has made the foregoing initial registration statement of a health spa, as required by section 407.327, RSMo; that s/he has read the foregoing registration statement and knows the contents thereof; that s/he is authorized to verify the foregoing registration statement; that the foregoing registration statement is true to her/his own knowledge; and that the foregoing registration statement was made for the purpose of complying with the requirements of sections 407.325 through 407.340, RSMo.

SIGNATURE _____

Subscribed and sworn to before me, this _____ day of _____ , 20 _____

_____ (Notary Public)

Enclose a $150 check ($100 filing fee plus $50 reinstatement fee). Make check payable to "Health Spa Regulatory Fund".