PK-MBM-PH-01-01E

REFLEXOLOGY & HEALTH ESTABLISHMENTS LICENCE APPLICATION FORM

Applicant /Nominee Photo

I, ____________________________(NRIC:_____________________________________) HEREBY DECLARE THAT THE INFORMATION GIVEN IN THIS FORM IS CORRECT AND I UNDERTAKE TO NOTIFY THE COUNCIL OF THE CITY OF MIRI OF ANY CHANGES IN THESE CIRCUMSTANCES.

I UNDERSTAND THAT THE COUNCIL IS ENTITLED TO REVOKE ANY LICENSES ISSUED IN CONNECTION WITH THIS APPLICATION ON ACCOUNT OF ANY FALSE INFORMATION GIVEN BY ME IN THIS FORM.

I ALSO UNDERSTAND THAT IT IS AN OFFENCE UNDER THE PENAL CODE (F.M.S. CAP 45) TO GIVE FALSE INFORMATION ON THIS FORM AND THAT I SHALL BE LIABLE ON CONVICTION BY A COURT TO A FINE OF RM2,000/- OR IMPRISONMENT FOR SIX MONTHS OR BOTH.

____

(SIGNATURE OF APPLICANT/*NOMINEE)

DATE :

PART I: PARTICULARS OF APPLICANT

<table>
<tr><td>1</td><td colspan="2">NAME FO APPLICANT/ *NOMINEE:</td><td colspan="4"></td><td>2</td><td>IDENTITY CARD NO.:</td><td colspan="4"></td></tr>
<tr><td>3</td><td colspan="2">PASSPORT NO:</td><td colspan="4"></td><td>4</td><td>DATE OF BIRTH:</td><td colspan="4"></td></tr>
<tr><td>5</td><td colspan="2">POSITION HOLD:</td><td colspan="4"></td><td>6</td><td>RACE:</td><td colspan="4"></td></tr>
<tr><td>7</td><td colspan="2">MARITAL STATUS:</td><td colspan="4"></td><td>8</td><td>SEX:</td><td></td><td>MALE</td><td></td><td>FEMALE</td></tr>
<tr><td>9</td><td colspan="2">TELEPHONE NO.:</td><td colspan="4"></td><td>10</td><td>RELIGION:</td><td colspan="4"></td></tr>
<tr><td>11</td><td>MEDICAL EXAMINATION:</td><td></td><td>FIT</td><td></td><td>NOT FIT</td><td></td><td>12</td><td>MARITAL STATUS:</td><td></td><td>MARRIED</td><td></td><td>SINGLE</td></tr>
<tr><td>13</td><td colspan="2">RESIDENTIAL ADDRESS:</td><td colspan="10"></td></tr>
<tr><td>14</td><td colspan="12">IF APPLICANT IS A *FIRM/CORPORATION, STATE:</td></tr>
<tr><td>a</td><td colspan="2">NAME OF FIRM/ CORPORATION:</td><td colspan="4"></td><td>b</td><td colspan="2">REGISTRATION NO.:</td><td colspan="3"></td></tr>
<tr><td>c</td><td colspan="2">ADDRESS OF FIRM/ CORPORATION:</td><td colspan="10"></td></tr>
<tr><td>d</td><td colspan="2">DATE OF REGISTRATION:</td><td colspan="4"></td><td>e</td><td colspan="2">TRADING LICENCE EXPIRY:</td><td colspan="3"></td></tr>
<tr><td>f</td><td colspan="2">TELEPHONE NO.:</td><td colspan="4"></td><td>g</td><td colspan="2">FAX NO. & E-MAIL ADD:</td><td colspan="3"></td></tr>
<tr><td>15</td><td colspan="2">TOTAL INVESTMENT:</td><td colspan="10">RM</td></tr>
<tr><td>16</td><td colspan="4">ARE YOU A HOLDER OF ANY LOCAL AUTHORITY’S LICENSE:</td><td></td><td>NO</td><td></td><td colspan="5">YES, PL. ATTACH COPY, IF ANY:_________________</td></tr>
<tr><td>17</td><td colspan="6">PREVIOUS CRIMINAL CONVICTION:</td><td></td><td>NO</td><td></td><td colspan="3">YES, __________________________</td></tr>
</table>

PART II: PARTICULARS OF REFLEXOLOGY & HEALTH ESTABLISHMENTS

1	ESTABLISHMENT NAME:				
2	ESTABLISHMENT ADDRESS:				
	LOT(S) NO. :____________________ ☐ G/FLOOR ☐ F/FLOOR ☐ OTHER:_________________ ____________________ ☐ G/FLOOR ☐ F/FLOOR ☐ OTHER:_________________ PARCEL NO.: ____________________________ BLOCK/SECTION NO.:_______________________________________ NAME OF ROAD :_________________________ POST CODE :____				
3	LAND TITLE CONDITION:		4	TOTAL FLOOR AREA:	SQ. METRES

PART III: APPLICATION FOR LICENSE(S)

1	BRIEF DESCRIPTION OF SERVICE(S) PROPOSED:	____ ____ ____ ____
2	BRIEF DESCRIPTION OF FACILITIES PROPOSED & THEIR QUANTITY	ROOMS :_____________BED(S)_____________CHAIRS(S)____________ SAUNA :_____________STEAM:___________AROMATHERAPY________ SPA :_____________OTHER: TO SPECIFY_________________________

PART V: INSTRUCTIONS

1. A PROCESSING FEE OF RM20.00 SHALL BE IMPOSED UPON REGISTRATION OF THIS LICENSE APPLICATION
2. APPLICANT SHALL PROVIDE UP-TO-DATE AND COMPLETE PARTICULARS TO FACILITATE LICENSE PROCESSING
3. TICK IN THE RELEVANT BOXES ☑
4. * DELETE WHICHEVER IS NOT APPLICABLE.

PART VI : CHECKLIST

		CHECKLIST
1.	RETURN THIS FORM TOGETHER WITH THE FOLLOWING DOCUMENTS:-	
I	COMPLETED APPLICATION FORMS	☐
II	ONE (1) COPY OF IDENTITY CARD (BOTH SIDES) OR PASSPORT OF APPLICANT/NOMINEE.	☐
III	ONE (1) COPIES OF PASSPORT SIZE PHOTOGRAPH OF THE APPLICANT/*NOMINEE	☐
IV	IF APPLICANT IS A FIRM/CORPORATION, ONE (1) OF THE *MEMORANDUM AND ARTICLES OF ASSOCIATION, AND *FORM 49 (RETURN GIVING DETAILS IN REGISTER OF DIRECTORS, MANAGERS AND CHANGE OF PARTICULARS) IN ACCORDANCE WITH THE COMPANIES ACT 1965.	☐
V	ONE (1) COPY OF THE TRADING LICENSE ISSUED IN ACCORDANCE WITH BUSINESSES, PROFESSIONS AND TRADES LICENSING ORDINANCE (CAP. 33[1958 EDITION])	☐
VI	ONE (1) COPY OF OCCUPATION PERMIT OF THE PREMISES CONCERNED	☐
	ONE (1) COPY OF LAND TITLE.	
VII	ONE (1) COPY OF TENANCY AGREEMENT/LETTER OF CONSENT OR CONFIRMATION FROM THEOWNER OF THE PREMISES(S)	☐
VIII	PHOTOGRAPH SHOWING THE FRONT & REAR PORTION OF THE PROPOSED PREMISES (3R SIZE)	☐
IX	TO SUBMIT PROPER BUILDING PLAN TO ENGINEERING SECTION BY REGISTERED CONSULTANT FIRM	☐
X	MEDICAL EXAMINATION FOR ALL THE MESSAEUR ENGAGED	☐

APPROVED/DISAPPROVED

Computer/Licence Officer

……………………………………………..……..

(Health Superintendent)

Date :…………………………………….

RECOMMENDED FOR APPROVAL

Approved/Disapproved

…………………………………………………

(Signature of Officer)

Date:……………………………………………….

REFLEXOLOGY & HEALTH ESTABLISHMENTS

EMPLOYEE REGISTER FORM (By 14(1)

PART 1 : PARTICULARS OF EMPLOYEE

1	NAME OF EMPLOYEE:			2		
3	PASSPORT NO.:			4		
5	WORK PERMIT NO.:			6		
7	NATIONALITY & COUNTRY OF ORIGIN			8		
9	MARITAL STATUS: ☐ MARRIED ☐ SINGLE			10	SEX: ☐ MARRIED ☐ SINGLE	
11	MEDICAL EXAMINATION ☐ FIT ☐ NOT FIT VALID TILL:					
12	RESIDENTIAL ADDRESS:			13	TELEPHONE NO.:	
14	QUALIFICATION & TRAINING:			15	CURRENT POSITION:	

PART II : PARTICULARS OF REFLEXOLOGY & HEALTH ESTABLISHMENTS

1	ESTABLISHMENT NAME:					
2	ESTABLISHMENT ADDRESS:					
3	LICENCE NO:			4	EXPIRY DATE	

PART III: DECLARATION

1/WE____IDDENTITY NO.:____________________HEREBY DECLARE ALL THE INFORMATION GIVEN ABOVE IS CORRECT AND TRUE.

____

( )

DATE:

PK-MBM-PH-01-2a

PEMERIKSAAN KESIHATAN UNTUK TUKANG URUT
MEDICAL EXAMINATION FOR MESSAEUR

Nama/*Name:*

Umur/*Age:*

Jantina/*Sex:*

No. Kad Pengenalan/*I.C.No./Passport:*

Kumpulan etnik/*Ethnic:*

Warganegara/*Citizenship:*

Tempat Kerja/*Place of work:*

Jenis kerja/*Type of work*

A. Sejarah kesihatan/*Medical History:*

Bil.	**Adakah anda mengalami perkara berikut:** ***Do you have any of the followings:***	**Ya/*Yes***	**No/*Tidak***
1.	Batuk-batuk berpanjangan terutama waktu malam *Prolonged cough especially at night*		
2.	Tiada selera makan dan kurang berat bandan *Loss of appetite and loss of weight*		
3.	Jangkitan kulit *Skin infection*		
4.	Merasa sakit pada kemaluan semasa kencing *Painful urination*		

B. Pemeriksaan Doktor/*Examination by Doctor:*

Bil.	**Pemeriksaan/*Examination***	**Catatan Doktor/*Doctor's Notes***
1.	Kulit/Skin	
2.	Mata/*Eyes*	
3.	Mulut/*Oral cavity*	
4.	Kelenjar/*Lymph nodes*	
5.	Saluran pernafasan/*Respiratory tract*	
6.	Abdomen/*Abdomen*	

C. Pemeriksaan Darah/*Blood Test for:*

Bil.	**Pemeriksaan/Examination**	**Positive**	**Negative**
1.	HIV		
2.	Hepatitis B		

Saya mengesahkan bahawa pemohon seperti nama di atas *layak/tidak layak untuk bekerja sebagai tukang urut.
*I certify that the person named above is *fit/not fit to work as masseur.*

Tandatangan/*Signature:*

Nama Doktor/*Name of Doctor:*

Nama Klinik/*Name of clinic:*

Tarikh/*Date:*

* Potong mana tidak perlu/*Delete if not applicable*