## General Massage Establishment Permit Application:

Please fill out and provide the following:

- ☐ Application (page 2)
- ☐ Written Operational Procedures (page 3)
- ☐ Practitioners' List (page 4)
- ☐ Referral to Planning/Zoning (page 5-6)
- ☐ San Francisco Police Department Background Check (page 7)
  **Applicant must submit fingerprints to SFPD for state and federal level fingerprint-based background check. You must email the SFPD form to sfpdpermits@sfgov.org. DO NOT MAIL IT IN.** *Police Background check expires after three (3) months.*
  *CAMTC certificate holders are not required to complete the SFPD background check.*
- ☐ Declaration of Healthy and Safe Working Conditions (page 8-9)
- ☐ Labor Law Checklist (page 10-11)
- ☐ Worker's Compensation Declaration (page 12-15)
- ☐ A copy of the lease, rental agreement or, if the applicant owns the premises, a copy of the deed.
- ☐ Floor plan drawing with dimensions depicting rooms and equipment.
  *Submit 2 sets of floor plans on 11 x 17" paper for brand new establishments only.*
- ☐ Copy of Business Registration Certificate
- ☐ Copy of SF Massage Practitioner OR CAMTC certificate
- ☐ Copy of current Identification Card or Driver's License

**PLEASE MAKE AN APPOINTMENT TO SEE AN INSPECTOR. THERE ARE NO DROP-IN APPOINTMENTS.**

Please Note: Failure to complete all forms and provide required documentation will result in your application being delayed or denied.

CITY AND COUNTY OF SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
ENVIRONMENTAL HEALTH BRANCH, 49 SOUTH VAN NESS AVE, SUITE 600, 94103

# APPLICATION FOR PERMIT TO OPERATE A MASSAGE ESTABLISHMENT

**Date of Application:**

| | | |
|---|---|---|
| **Type of Establishment:** ☐ **General Massage** ☐ **Sole Practitioner** ☐ **OutCall Service** | | **FACILITY ID NO.** |
| **TRADENAME (DBA):** **ADDRESS:** | ☐ Sole Owner ☐ Partnership ☐ Corporation | ☐ New Installation ☐ Ownership Change ☐ Reclassification ☐ Record Purpose |
| Remodel? ☐ Yes ☐ No | | |

| | | | |
|---|---|---|---|
| **CROSS STREET:** | **EMAIL ADDRESS:** | **BUSINESS PHONE NO.** | **CELL PHONE NO.** |

| | |
|---|---|
| **Name** of:<br>a) Person to whom permit will be issued, or<br>b) Corporation name and names of principal Officers and stockholders with more than or equal to 10% ownership (include percentage of each listed individual) | **Home Address** of:<br>a) each applicant with birth date, or<br>b) each practitioner for Solo Practitioner Establishment, or<br>c) Corporation and Corporate Officers<br><br>**Contact Person:** |
| **Emergency name & phone:** | **Home Telephone:** |

**Has any applicant**, including corporate officers and stockholders, **EVER BEEN CONVICTED OF ANY FELONY OR MISDEMEANOR** ☐ No ☐ Yes
*If yes*, please attach a list of each conviction along with the date of the conviction.

**Are you currently pending any investigation regarding any felonies, misdemeanors or lewd conduct** ☐ No ☐ Yes
*If yes*, please attach a list of each conviction along with the date of the conviction.

**Have you ever had any massage license or massage establishment licenses denied, suspended or revoked:** ☐ No ☐ Yes
*If yes*, please attach information about the license denial, revocation or suspension, inlcuding dates.

**ATTACH:**
1) WRITTEN OPERATIONAL PROCEDURES WHICH DESCRIBE THE EXACT NATURE OF THE SERVICES TO BE PROVIDED
2) PRACTITIONER LIST (FOR MASSAGE ESTABLISHMENTS). PROVIDE COPY OF CURRENT SF MASSAGE PRACTITIONER LICENSE OR CALIFORNIA MASSAGE THERAPY COUNCIL(CAMTC) CERTIFICATE.
3) LIST OF PREVIOUS MASSAGE PERMITS OR LICENSES HELD

I declare under penalty of perjury the information on this application and in other materials submitted in support of this application are true and correct. I hereby consent to all necessary inspections made pursuant to the Massage Ordinance and incidental to the issuance of any exemption, Registration or Permit, and operation of this business. I have checked with the Planning Department prior to submitting this application to verify that this location is zoned for a Massage Establishment. **I understand that once submitted, the application fee is nonrefundable.**

***SIGNATURE(S) OF APPLICANT(S)**

X _____ X _____

X _____ X _____

**If Partnership, all partners must sign. If Corporation, authorized Officer must sign. Attach extra sheets if necessary.*

**FOR OFFICE USE ONLY**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Filing Fee & Receipt # | | Zoning Referral | | Lease Agreement | | Previous Permits | |
| | | | | Practitioner list | | Home Addresses | |
| Out of Business Notification | | Labor & Workers' Comp | | Owner(s) Background Check | | Corporate Address | |

**INSPECTOR'S REPORT**

To the Director of Public Health:
After having made a careful inspection in the above case on _____ 20
I RECOMMEND the issuance of a New Permit to operate ☐
I DISAPPROVE the issuance of a New Permit to operate ☐ for the following reasons:

**PRINCIPAL INSPECTOR** **INSPECTOR**

| HEARING DATE | APPROVED Y ☐ N ☐ | DISTRICT NO. | CENSUS TRACT | PERMIT NO. | TYPE OF PERMIT / CLASSIFICATION |
|---|---|---|---|---|---|
| | | | | | |

DATE: _____

## WRITTEN OPERATIONAL PROCEDURES

**DBA:** _____ **Bus. Phone:** _____

**Address:** _____ **OnSite Mgr:** _____

MANAGER DURING NORMAL WORKING HRS

| **TYPE OF ESTABLISHMENT:** | EMPLOYEES: | **OPERATIONS:** | **# OF ROOMS:** |
|---|---|---|---|
| ☐ GENERAL WITHOUT OUTCALL ☐ GENERAL W/ OUTCALL<br>☐ SOLO WITHOUT OUTCALL ☐ SOLO WITH OUTCALL<br>☐ OUTCALL ONLY | TOTAL: _____<br>Male Female | DAYS: _____<br>HOURS: _____ | **THERAPY:** _____<br>**TOILET:** _____ |

DESCRIBE THE TYPE OF MASSAGE THERAPY USED BY YOUR PRACTITIONERS, (I.E. SHIATSU, SWEDISH, DEEP TISSUE, ETAL.)

| IS THIS BUSINESS AN ACCESSORY TO AN EXISTING/NEW BUSINESS? | **ATTACH A FLOOR PLAN** OF YOUR ESTABLISHMENT SHOWING: |
|---|---|
| N ◯ Y ◯ IF YES, WHAT IS IT? _____ | SHOWERS, TOILETS, THERAPY & CHANGE ROOMS, HANDWASH & MOP SINKS, AND CLEAN & DIRTY LINEN STORAGE. |

I declare under penalty of perjury that the information on this business plan, to the best of my knowledge, is true and correct. I hereby consent to all necessary inspections made pursuant to the Massage Ordinance and incidental to the issuance of any exemption, Registration or Permit, and operation of this business.

| NAME (PRINTED) | SIGNATURE | DATE |
|---|---|---|
| | | |

DATE:_____

## PRACTITIONERS' LIST FOR

◯ EXISTING ◯ NEW

**DBA:**_____ **Bus. Phone:**_____

**Address:**_____ **OnSite Mgr:**_____

MANAGER DURING NORMAL WORKING HRS

| | FIRST & LAST NAME OF MASSAGE PRACTITIONER<br>*Provide copy of current SF Massage license certificate OR CAMTC certificate* | PRACT.<br>Check one | PERMIT#<br>(MP) | Office Use ONLY<br>Active? |
|---|---|---|---|---|
| 1) | | CAMTC ◯ DPH ◯ | | ☐ YES<br>☐ No Permit |
| 2) | | CAMTC ◯ DPH ◯ | | ☐ YES<br>☐ No Permit |
| 3) | | CAMTC ◯ DPH ◯ | | ☐ YES<br>☐ No Permit |
| 4) | | CAMTC ◯ DPH ◯ | | ☐ YES<br>☐ No Permit |
| 5) | | CAMTC ◯ DPH ◯ | | ☐ YES<br>☐ No Permit |
| 6) | | CAMTC ◯ DPH ◯ | | ☐ YES<br>☐ No Permit |
| 7) | | CAMTC ◯ DPH ◯ | | ☐ YES<br>☐ No Permit |
| 8) | | CAMTC ◯ DPH ◯ | | ☐ YES<br>☐ No Permit |
| 9) | | CAMTC ◯ DPH ◯ | | ☐ YES<br>☐ No Permit |
| 10) | | CAMTC ◯ DPH ◯ | | ☐ YES<br>☐ No Permit |
| 11) | | CAMTC ◯ DPH ◯ | | ☐ YES<br>☐ No Permit |
| 12) | | CAMTC ◯ DPH ◯ | | ☐ YES<br>☐ No Permit |

PLEASE ATTACH ANOTHER PAGE IF THERE ARE MORE THAN TWELVE PRACTITIONERS AT THIS FACILITY.

| HEALTH DEPARTMENT USE ONLY | | | | | |
|---|---|---|---|---|---|
| Date Application Filed: | | Health District: | 3 4 5 Massage OTHER | | |
| Date to Zoning: | | Inspector: | | Phone | |
| Date from Zoning: | | Supervisor's Initials: | | Date: | |

**Please submit to:**
CITY AND COUNTY OF SAN FRANCISCO
**DEPARTMENT OF PUBLIC HEALTH, ENVIRONMENTAL HEALTH**
49 SOUTH VAN NESS AVENUE, STE. 600, SAN FRANCISCO, CA 94103 - (415) 252-3800

# Zoning Referral for Health Permit

## 1. Business Information

BUSINESS STREET ADDRESS:

NAME OF BUSINESS:

| TOTAL SQUARE FOOTAGE OF AREA (includes storage and bathroom areas): | OUTDOOR SEATING AREA? | OUTDOOR FOOD/DRINK SERVICE? |
|---|---|---|
| | ☐ Yes ☐ No | ☐ Yes ☐ No |

WHAT FLOOR OF THE BUILDING WILL THE BUSINESS OCCUPY?

☐ Ground (First) Level ☐ Second Level ☐ Third Level ☐ Other Level:

1a. Change of Use (depending of the zoning of the property, neighborhood notification may be required): ☐ Yes ☐ No
If yes, what is the existing use? _____

1b. Change of business ownership? ☐ Yes ☐ No
If not a change of ownership, then is it a new establishment? ☐ Yes ☐ No

1c. Is the establishment vacant? ☐ Yes ☐ No
If yes, how long was the establishment vacant? _____

1d. Do you propose to alter the interior or exterior of the establishment? ☐ Yes ☐ No
If yes, what is the Building Permit Application Number? _____

1e. Is the business a Formula Retail Chain or Franchise with 11 or more locations within the U.S.? ☐ Yes ☐ No
If yes, a Formula Retail Affidavit is **required**. (Formula Retail - P.C. Sec. 301.1)

1f. Does this business sell alcoholic beverages? ☐ Yes ☐ No
If yes, read page two for category restrictions.

## 2. Type of Operation, please check:

☐ **Restaurant** ☐ **Limited Restaurant**

☐ **Bar** ☐ **General / Specialty Grocery**

☐ **Catering** ☐ **Cottage Food Operator**

☐ **Massage** *(if applicable, please select your type of massage business below)*

☐ Chair/Foot Massage Only ☐ Sole Practitioner Establishment ☐ Within a gym, hotel, or hospital

☐ **Other:**

2a. Accessory Use (business within another business)? ☐ Yes ☐ No **If yes, plans are required.**

2b. Days / Hours of Operation:

_____

## 3. Applicant's Affidavit

| NAME: | |
|---|---|
| | ☐ Property Owner ☐ Authorized Agent |
| MAILING ADDRESS: (STREET ADDRESS, CITY, STATE, ZIP) | |
| | |
| PHONE: | EMAIL: |
| ( ) | |

1. I am the owner or authorized agent of the owner of this property.
2. The information presented on this application is true and correct to the best of my knowledge.
3. Additional information or applications may be required in order to render this application complete.

Applicant's Signature: _____ Date: _____

## PLANNING DEPARTMENT USE ONLY

| BLOCK / LOT: | ZONING: | RUD / SUD: | LCU / NCU: |
|---|---|---|---|
| | | | |

| ZONING REFERRAL NUMBER: | OFFICIAL SITE ADDRESS (if different): |
|---|---|
| | |

| BPA NUMBER: | 312 NOTICE COMPLETE: | PRELIMINARY SCREENING? |
|---|---|---|
| | ☐ Yes ☐ No | ☐ Yes ☐ No |

| CASE NO.: | MOTION NO.: | EFFECTIVE DATE: | CONDITIONS: |
|---|---|---|---|
| | | | ☐ Yes ☐ No |

OTHER:

ADDITIONAL DOCUMENTS REQUIRED:

☐ SITE PLAN ☐ MASSAGE DOCS ☐ OTHER:

| RECOMMENDATION: | Per Planning Code Section: |
|---|---|
| ☐ APPROVAL ☐ DISAPPROVAL | |

CONDITIONS OF APPROVAL:

COMMENTS:

AUTHORIZATION:

Signature: _____ Date: _____

Printed Name: _____ Phone: (_____) _____

**Restaurant** [790.91]: A retail eating and/or drinking use which serves prepared, ready-to-eat cooked foods to customers for consumption on or off the premises and which has seating. It may have a Take-Out Food[790.122] as a minor and incidental use. It may provide on-site alcohol sales for drinking on the premises (ABC Types 41, 47, 49, 59, or 75); however, if it does it is required to operate as a Bona Fide Eating Place[790.142]. It is not required to operate within an enclosed building per Section 703.2(b)(1) so long as it is also a Mobile Food Facility[102.34]. Any outdoor seating and/or dining area is subject to regulation as an Outdoor Activity Area.

**Limited Restaurant** [790.90]: A retail eating and/or drinking use which serves ready-to-eat foods and/or drinks to customers for consumption on or off the premises, that may or may not have seating. It may provide off-site beer and/or wine sales for consumption off the premises with an ABC Type 20 license within the accessory use limits of Section 703.2(b)(1)(C)(vi).

**Bar** [790.22]: A retail use which provides on-site alcoholic beverage sales for drinking on the premises. ABC License Types include: 42, 48, or 61 (no minors permitted on premises) and 42 or 60 (minors permitted on premises).

**General Grocery** [790.102(a)]: A retail food establishment that offers a diverse variety of unrelated, non-complementary food and non-food commodities. May provide beer, wine, and/or liquor sales for consumption off the premises with ABC Type 20 or 21 within the accessory use limits of Section 703.2(b)(1)(C)(vi). May prepare minor amounts or no food on-site for immediate consumption

**Specialty Grocery** [790.102(b)]: A retail food establishment that offers specialty food products, such as baked goods, pasta, cheese, confections, coffee, meat, seafood, produce, artisanal goods and other specialty food products, and may also offer additional complementory food and non-food commodities. May provide beer, wine, and/or liquor sales for consumption off the premises with ABC Type 20 or 21 within the accessory use limits of Section 703.2(b)(1)(C)(vi). May prepare minor amounts or no food on-site for immediate consumption.

**Other may include: Massage Establishment** [790.60], **Tobacco Paraphernalia Establishment** [790.123], **Medical Cannabis Dispensary** [790.141], **Service, Personal** [790.116], **Take-out Food** [790.122]

For more information regarding types of establishments, zoning, and Planning Code questions, you may go on-line to www.sfplanning.org or contact the Planning Information Center (PIC) for more information:

**Planning Information Center (PIC)**
1660 Mission Street, First Floor
San Francisco CA 94103-2479
TEL: **415.558.6377**

City and County of San Francisco
**DEPARTMENT OF PUBLIC HEALTH**
**ENVIRONMENTAL HEALTH**

To: San Francisco Police Department
Permits Unit
1245 3rd Street, 5th Floor,
San Francisco, CA 94158
Phone: (415) 553-1115
Email: sfpdpermits@sfgov.org
By Appointment Only

Subject: **BACKGROUND CHECK AND CLEARANCE FOR MASSAGE APPLICANT**

We have received the following applicant's information for: ☐ Outcall Service
☐ General Massage Establishment
☐ Sole Practitioner Massage Establishment

| | | | |
|---|---|---|---|
| Applicant's Name: | | | Date: |
| Doing Business As (DBA): | | | BAN: |
| Facility Address: | | | |
| Home Address: | | | |
| Phone Number: | | E-Mail: | |
| Social Security #: | | Place of Birth: | |
| Driver's License # (or ID #/Passport #): | | Date of Birth: | |
| Eye Color: | Hair Color: | Height: | Weight: |

*****DO NOT WRITE BELOW – FOR SFPD USE ONLY*****

SFPD, may we please have your recommendation in the space provided below.

Does the applicant qualify for First Year Free (FYF) ☐ YES ☐ NO

A preliminary criminal background query has indicated:

☐ In the previous 5 years, the applicant **has not been** convicted of any offenses outlined in San Francisco Health Code Sections 29.29(c)(4) & (5), 29.12.

☐ In the previous 5 years, the applicant **has been** convicted of one or more of the offenses outlined in San Francisco Health Code Sections 29.29(c) (4) & (5), 29.12.

☐ The applicant has **any** prior felony or misdemeanor convictions. San Francisco Health Code Sections 29.26(b)(6) and 29.11(b)(7). (List Below)

Prior Felony or Misdemeanors: _____

_____

Reviewed by: _____
INSPECTOR (PRINT) STAR # SIGNATURE

Telephone no: _____ Date: _____

**PLEASE EMAIL THIS FORM TO SFPDPERMITS@SFGOV.ORG AND A SFPD STAFF WILL CONTACT YOU TO SCHEDULE YOUR APPOINTMENT. YOU MAY CONTACT THE SFPD PERMITS UNIT FOR THE CURRENT BACKGROUND CHECK FEE.**

City and County of San Francisco
**DEPARTMENT OF PUBLIC HEALTH**
**ENVIRONMENTAL HEALTH**

# Declaration of Healthy and Safe Working Conditions
# Declaración de Condiciones de Trabajo Sanas Y Seguras
# 健康及安全工作條件聲明
# Deklarasyon ng Mabuti at Ligtas na Kondisyon sa Trabaho

The Department of Public Health is responsible for ensuring healthy and safe conditions for those working and living in San Francisco. Establishments permitted by the Department must remain compliant with all laws.

*El Departamento de Salud es responsable de asegurar condiciones saludables y seguras para las personas que trabajan y viven en San Francisco. Establecimientos permitidos por el Departamento deben cumplir con todas las leyes.*

衛生署是負責確保於三藩市工作及居住的人士有一健康和安全的環境。從衛生署取得許可營運的設施/場所必須保持遵守所有法律。

Ang Kagawaran ng Pampublikong Kalusugan ay may pananagutan para sa pagtiyak ng mabuti at ligtas na mga kondisyon para sa mga nagtatrabaho at naninirahan sa San Francisco. Ang mga establisyemento na pinahihintulutan ng Kagawaran ay dapat manatiling sumusunod sa lahat ng mga batas.

Owner/Operator: _____

DBA/Name of Business: _____

Business Address: _____ San Francisco, CA 941

**翻譯及你的簽署聲明在本頁後面。**

***¡Ojo! La traducción y firma de su declaración se encuentra en la parte posterior de esta página.***

**Ang pagsasalin at paglagda ng iyong deklarasyon ay nasa likod ng pahinang ito.**

1. I understand that this business must comply with all local, state, and federal labor laws in order to obtain and maintain a valid Permit To Operate from the Department. I affirm that as an operator of the above business, I am aware of and agree to comply with the following laws when applicable to my business:
   - San Francisco Labor Codes ❍ Yes ❍ No
   - California Labor Code Division 4—Have and maintain Workers Compensation Insurance or be self-insured) ❍ Yes ❍ No
   - California Labor Code Division 2—Employment Regulation and Supervision ❍ Yes ❍ No
   - California Labor Code Division 5—Occupational Health and Safety ❍ Yes ❍ No
   - All other federal, state, and local labor codes ❍ Yes ❍ No
2. I will request my provider of Workers Compensation Insurance to designate as a "Certificate Holder" the SF Environmental Health Branch at 49 S Van Ness Ave Suite 600, San Francisco, CA 94103. ❍ Yes ❍ No

I am the owner or authorized agent of the owner of this business. I declare under penalty of perjury that the information on this Declaration of Healthy and Safe Working Conditions is true and correct.

Print Name _____ Signature _____ Date _____

**I acknowledge that failure to comply with all applicable federal, state, and local labor laws may result in suspension or revocation of my Permit To Operate issued by the San Francisco Department of Public Health or a referral to the applicable federal, state, or local agency for enforcement.**

Print Name _____ Signature _____ Date _____

1. 為了獲得與保持公共衛生署發出的有效營運許可証，我明白此設施/場所必須遵守全部本地、州、和聯邦政府的勞工法例。我申明作為上述設施/場所的營運商，我了解並同意遵守以下的法例 ：

- *三藩市勞工法* ○會 ◉不會
- *加州勞工法第4部分 - 具備維護工人賠償保險或自我保險* ○會 ◉不會
- *加州勞工法第2部分 - 就業監管與監督* ○會 ◉不會
- *加州勞工法第5部分 - 職業健康及安全* ○會 ◉不會
- *所有其它的聯邦、州、和本地勞工法* ◉會 ◉不會

2. 我將會要求我的工人賠償保險提供者指定位於49 S Van Ness Ave.，#600，San Francisco，CA 94103的三藩市環境衛生部（SF Environmental Health Branch）為“證書持有者”。 ◉會 ◉不會

本人是本企業的擁有者或其授權代理人。在會觸及偽證處罰情況下，本人聲明本健康及安全工作條件聲明中的資訊均是真實與正確。

以正楷英文清楚寫上姓名 簽名 日期

**我確知如不遵守所有實施的聯邦、州、及本地勞工法例會導致三藩市公共衛生署簽發給我的營運許可証被中止或撤銷或我會被轉介到相關的聯邦、州、或本地執法機構。**

清楚寫上姓名 簽名 日期

1. Yo entiendo que este negocio debe cumplir con todas las leyes laborales locales, estatales y federales con el fin de obtener y mantener un Permiso Para Operar válido del Departamento de Salud Pública. Yo afirmo que como operador del negocio mencionado arriba, estoy consciente de y acepto cumplir con las siguientes leyes, cuando si aplicable a mi negocio:
   - Ordenanzas laborales de San Francisco ❍ Sí ❍ No
   - División 4 del Código Laboral de California -Tener y mantener Seguro de Compensación de Trabajadores o tener su propio seguro) ❍ Sí ❍ No
   - División 2 del Código Laboral de California - Regulación y Supervisión del Empleo ❍ Sí ❍ No
   - División 5 del Código Laboral de California - Salud y Seguridad Ocupacional ❍ Sí ❍ No
   - Todos los demás códigos laborales federales, estatales y locales ❍ Sí ❍ No
2. Solicitaré a mi proveedor de Seguro de Compensación del Trabajador que designe como "Titular de Certificado" la Subdivisión de Salud Ambiental de SF en el 49 S Van Ness Ave., # 600, San Francisco, CA 94103 ❍ Sí ❍ No

Soy el propietario o un representante autorizado del propietario de este negocio. Declaro bajo pena de perjurio que la información en esta Declaración de Condiciones Trabajo Saludables y Seguras es verdadera y correcta.

Escribir Nombre Firma Fecha

**Yo reconozco que incumplimiento de todas las leyes laborales federales, estatales y locales puede resultar en la suspensión o revocación de mi Permiso Para Operar emitido por el Departamento de Salud Pública de San Francisco o ser referido a la agencia federal, estatal, o local aplicable para hacer cumplir la ley.**

Escribir Nombre Firma Fecha

1. Nauunawaan ko na itong negosyo ay dapat sumunod sa lahat ng lokal, estado, at pederal na batas sa paggawa upang makakuha ng at mapanatili ang isang may-bisang permiso na mangasiwa mula sa Kagawaran. Pinagtitibay ko na bilang isang tagapangasiwa ng negosyong ito, nababatid at sinasang-ayunan ko ang mga sumusunod na batas kung naaangkop sa aking negosyo
   - San Francisco Labor Codes ❍ Oo ◉ Hindi
   - California Labor Code Division 4—Magkaroon at magpanatili ng Workers Compensation Insurance o self-insurance. ❍ Oo ◉ Hindi
   - California Labor Code Division 2—Regulasyon ng trabaho at pangangasiwa ❍ Oo ◉ Hindi
   - California Labor Code Division 5—Kalusugan at kaligtasan sa trabaho ❍ Oo ◉ Hindi
   - Lahat ng iba pang mga pederal, estado at lokal na batas sa paggawa ❍ Oo ◉ Hindi
2. Ako ay hihiling sa aking tagalaan ng Workers Compensation Insurance upang maitalaga bilang isang "Certificate Holder" ang SF Environmental Health Branch sa 49 S Van Ness Ave., # 600, San Francisco, CA 94103 ❍ Oo ❍ Hindi

Ako ang may-ari o ang awtorisadong ahente ng may-ari ng negosyong ito. Idinedeklara ko sa ilalim ng parusa sa panunumpa nang walang katotohanan na totoo at tama ang impormasyon sa Deklarasyon ng Mabuti at Ligtas na Kondisyon sa Trabaho na ito.

Pangalan Lagda Petsa

**Tinatanggap ko na ang hindi pagsunod sa lahat ng mga pederal, estado, at lokal na batas sa paggawa ay maaaring magdulot ng suspensyon o pagbawi ng aking permiso na mangasiwa na ibinigay ng Kagawaran ng Pampublikong Kalusugan ng San Francisco, o isang pagsangguni sa angkop na pederal, estado, o lokal na ahensiya para sa pagpapatupad.**

Pangalan Lagda Petsa

# Labor Law Checklist For San Francisco Business Owners

As a small business owner, you are responsible for complying with federal, state, and local labor laws. This checklist is for your use and does not need to be submitted. It will help you comply with the most important San Francisco and California labor laws. It is not a complete list, and it is not intended as legal advice. Contact the labor law agencies listed at the end of this checklist for detailed information.

## Wages

- ❑ 1. Pay all workers the *San Francisco* Minimum Wage, which adjusts annually. Maintain time and payroll records.
- ❑ 2. Pay overtime pay of 1.5 times for hours over 8 per day or 40 per week.
- ❑ 3. Pay all wages within legal timeframe when employees terminate their employment.
- ❑ 4. Display posters about wages, unemployment, and pay day.

## Rest Breaks

- ❑ 5. Provide 10 minutes of paid break for every 4 hours worked.
- ❑ 6. Provide 30 minutes of uninterrupted unpaid break for every 5 hours worked.

## Health Benefits

- ❑ 7. Provide 1 hour of paid sick leave for every 30 hours worked.
- ❑ 8. Contribute towards health care if you have more than 20 employees.
- ❑ 9. Provide up to 12 weeks of unpaid medical leave if you have more than 50 employees.
- ❑ 10. Purchase workers compensation insurance for all employees.
- ❑ 11. Deduct disability insurance.
- ❑ 12. Display posters about sick pay and workers compensation benefits.

## Young Workers

- ❑ 13. Ask for work permits if under 18.
- ❑ 14. Schedule them to work not too many hours or too early or late in the day.
- ❑ 15. Assign teens low-risk job tasks.

## Safety and Health Protection

- ❑ 16. Prepare and implement an Injury and Illness Prevention Program.
- ❑ 17. Identify and correct unsafe and hazardous conditions.
- ❑ 18. Establish safe working procedures.
- ❑ 19. Provide and maintain all safety tools and equipment that employees need.
- ❑ 20. Make available to employees a Material Safety Data Sheets for each chemical used.
- ❑ 21. Provide training on hazards, safe operating procedures, and the use of safety equipment. Use visual aids (signs, labels, posters) to reinforce training.
- ❑ 22. Keep 3 feet clearance (no storage) in front of electrical panels. Replace damaged electrical cords. Replace missing covers of electrical boxes.
- ❑ 23. Inspect first aid kits regularly, replenish materials as needed.
- ❑ 24. Keep aisles and exit route clear of obstructions. Keep floors clean and dry or supply mats. Clean up spills immediately.
- ❑ 25. Report serious injury, illness, or death to Cal-OSHA immediately.
- ❑ 26. Keep records of injuries and illnesses as well as insurance claims related to work place injuries. If using a Log 300, records workplace injuries and illnesses on the log.
- ❑ 27. Provide medical exams if required by law and provide employees access to their medical records and results of workplace chemical exposure records.
- ❑ 28. Post Cal-OSHA Safety & Health Protection on the Job poster.

OTHER GENERAL RESPONSIBILITIES

- ❑ 29. Provide equal employment opportunities regardless of race, color, religion, sex, or national origin, disabilities, marital status, or age.
- ❑ 30. Prohibit sexual harassment or other types of harassment towards employees who have refused to do unsafe work or have made a complaint to a labor law enforcement agency.
- ❑ 31. Allow workers to organize and form a union.

WHERE TO GET MORE INFORMATION

| Item # | Agency |
|---|---|
| 1 | SF-OSLE |
| 2 | CA-DLSE |
| 3 | CA- DLSE |
| 4 | SF-OSLE |
| 5 | CA- DLSE |
| 6 | CA- DLSE |
| 7 | SF-OSLE |
| 8 | SF-OSLE |
| 9 | FEH |
| 10 | WC |
| 11 | EDD |
| 12 | WC, SF-OSLE |
| 13 | CA- DLSE |
| 14 | CA- DLSE |
| 15 | CA- DLSE |
| 16 | Cal-OSHA |
| 17 | Cal-OSHA |
| 18 | Cal-OSHA |
| 19 | Cal-OSHA |
| 20 | Cal-OSHA |
| 21 | Cal-OSHA |
| 22 | Cal-OSHA |
| 23 | Cal-OSHA |
| 24 | Cal-OSHA |
| 25 | Cal-OSHA |
| 26 | Cal-OSHA |
| 27 | CA-OSHA |
| 28 | Cal-OSHA |
| 29 | FEH |
| 30 | FEH |
| 31 | NLRB |

**Agency List**

**(CA-DLSE)** Department of Industrial Relations
Division of Labor Standards Enforcement
455 Golden Gate Ave., 10th fl.
San Francisco, CA 94102
(415) 703-5300 www.dir.ca.gov/dlse

**(Cal-OSHA)** Department of Industrial Relations
California Occupational Safety and Health Administration
121 Spear Street, Room 430
San Francisco, CA 94105
(415) 972-8670 www.dir.ca.gov/dosh

**(EDD)** Employment Development Department
745 Franklin Street, #300
San Francisco, CA 94102
(800) 480-3287 www.edd.ca.gov

**(FEH)** Department of Fair Employment and Housing
2218 Kausen Dr., #100
Elk Grove, CA 95758
(800) 884-1684 www.dfeh.ca.gov

**(NLRB)** National Labor Relations Board
901 Market Street, #400
San Francisco, CA 94103
(415) 356-5130 www.nlrb.gov

**(SF-OSLE)** Office of Labor Standards Enforcement
1 Dr. Carlton B. Goodlett Place, Room 430
San Francisco, CA 94102
(415) 554-6271 www.sfgov.org/olse

**(WC)** Department of Industrial Relations
Division of Workers' Compensation
455 Golden Gate Ave., 2nd fl.
San Francisco, CA 94102
(415) 703-5011 www.dir.ca.gov/dwc

Adopted from educational materials produced by the Labor Occupational Health Program of the University of California Berkeley and the California Department of Industrial Relations. Prepared by: Environmental Health Section of the San Francisco Department of Public Health, January 2010

City and County of San Francisco
**DEPARTMENT OF PUBLIC HEALTH**
**ENVIRONMENTAL HEALTH**

# Workers' Compensation Declaration for Regulated Businesses

Owner/Operator: _____

DBA/Name of Business: _____

Address of Business: _____ SFDPH Permit Type: _____

I understand that this business must comply with the Workers' Compensation laws of the State of California to obtain and maintain a valid permit to operate from the San Francisco Department of Public Health. I hereby affirm one of the following declarations:

☐ I have and will maintain a "**Certificate of Insurance**" for workers' compensation insurance, as required by Section 3700 of the Labor Code, for the performance of the work for which this permit is issued. My workers' compensation insurance carrier and policy number are:

_____
Carrier

_____
Policy Number

☐ I have and will maintain a "**Certificate of Consent to Self-Insure**" for workers' compensation, as provided for by Section 3700 of the Labor Code, for the performance of the work for which this permit is issued.

☐ I certify that this business is **not subject to requirements of Section 3700 of the Labor Code** at this time.
I agree that if this business employs any person in any manner so as to become subject to the workers' compensation laws of the State of California and the provisions of Section 3700 of the Labor Code, I will comply with those provisions and I will provide proof of coverage as required by the San Francisco Department of Public Health.

Warning: Failure to secure workers' compensation coverage is unlawful, and shall subject an employer to criminal penalties and civil fines up to **one hundred thousand dollars ($100,000)**, in addition to the cost of compensation, damages as provided in Section 3706 of the Labor Code, interest and attorney's fees.

**I am the owner or authorized agent of the owner of this business. I declare under penalty of perjury that the information on this Worker's Compensation Declaration is true and correct.**

_____ _____
Date Print Name Applicant Signature

DPH Use Only: ☐ Signature Verified by _____ Date:_____

City and County of San Francisco
**DEPARTMENT OF PUBLIC HEALTH**
**ENVIRONMENTAL HEALTH**

# 受監管企業的勞工賠償聲明

持有人/經營者（Owner/Operator）:_____

企業以這名稱經營/企業名稱（DBA/Name of Business）:_____

企業地址（Name of Business）:_____ 三藩市公共衛生署許可証類型（SFDPH Permit Type）:_____

本人瞭解本企業必須遵守加州勞工賠償法律的規定，以獲得並維持三藩市公共衛生署 (San Francisco Department of Public Health) 核發的有效運營許可。本人在此確認下列其中一項聲明：

☐ 爲執行此許可範圍內工作的勞工提供賠償保險，本人目前已經及未來也會依據《勞工法》第 3700 段的規定獲得並且維持一份**「保險證書 (Certificate of Insurance)」**。本人的勞工賠償保險公司與保單號碼如下：

_____
保險公司

_____
保單號碼

☐ 爲執行此許可範圍內工作的勞工提供賠償保險，本人目前已經及未來也會依據《勞工法》第 3700 段的規定獲得並且維持一份**「同意自我保險的證書 (Certificate of Consent to Self-Insure)」**。

☐ 本人證明本企業目前**不受《勞工法》第 3700 段規定的約束**。
本人同意倘若本企業以任何方式僱用任何人，將受到加州勞工賠償法律以及《勞工法》第 3700 段規定的約束，本人將遵守該法例的規定並且將會依據三藩市公共衛生署的規定提供投保證明。

警告：未能提供勞工賠償保險是不合化的，除按《勞工法》第 3706 段規定作出補償、賠償、付利息以及律師費外，僱主還會受到刑事處罰以及最高達**十萬美元 ($100,000)** 的民事罰款。

**本人是本企業的擁有者或授權代理人。在會觸及偽證處罰情況下，本人聲明本勞工賠償聲明中的資訊均是真實與正確。**

| 日期 | 以正楷英文清楚寫上姓名 | 申請人簽名 |
|---|---|---|

DPH Use Only: ☐ Signature Verified by ____

# Declaración de Compensación del Trabajador para Negocios Regulados

Owner/Operator: _____

DBA/Name of Business: _____

Address of Business: _____ SFDPH Permit Type: _____

Entiendo que este negocio debe cumplir con las leyes de Compensación del Trabajador del Estado de California para obtener y mantener un permiso válido para operar emitido por el Departamento de Salud Pública de San Francisco. Aafirmo una de las siguientes declaraciones:

☐ Tengo y mantendré un "**Certificado de Seguro (Certificate of Insurance)**" para el seguro de Compensación del Trabajador, según lo exige la sección 3700 del Código Laboral, para la ejecución de los trabajos para los que se emitió este permiso. Mi agente de seguro de Compensación del Trabajador y el número de la póliza son:

_____
Agente

_____
Número de póliza

☐ Tengo y mantendré un "**Certificado de Consentimiento de Seguro por Cuenta Propia (Certificate of Consent to Self-Insure)**" para la Compensación del Trabajador, según lo establecido en la sección 3700 del Código Laboral, para la ejecución de los trabajos para los que se emitió este permiso.

☐ Certifico que este negocio **no está sujeto a los requisitos de la sección 3700 del Código Laboral** en este momento.

Acepto que si este negocio emplea alguna persona de forma tal que estaría sujeto a las leyes de Compensación del Trabajador del Estado de California y las disposiciones de la sección 3700 del Código Laboral, cumpliré con dichas disposiciones y presentaré una prueba de cobertura según lo requerido por el Departamento de Salud Pública de San Francisco.

**Advertencia**: No tener cobertura de Compensación del Trabajador es ilegal y el empleador estará sujeto a sanciones penales y multas civiles de hasta **cien mil dólares ($100,000)**, además de los gastos de compensación, daños según lo previsto en la sección 3706 del Código Laboral, intereses y honorarios de abogados.

**Soy el propietario o un representante autorizado del propietario de este negocio. Declaro bajo pena de perjurio que la información en esta Declaración de Compensación del Trabajador es verdadera y correcta.**

_____ _____
Fecha Nombre en letra de imprenta Firma del solicitante

DPH Use Only: ☐ Signature Verified by ____

City and County of San Francisco
**DEPARTMENT OF PUBLIC HEALTH**
**ENVIRONMENTAL HEALTH**

# Deklarasyon ng Kompensasyon sa Mga Manggagawa Para sa Mga Negosyong Sumasailalim sa Regulasyon

Owner/Operator: _____

DBA/Name of Business: _____

Address of Business: _____ SFDPH Permit Type: _____

Nauunawaan ko na dapat sumunod ang negosyong ito sa mga batas ng Kompensasyon sa Mga Manggagawa (Workers' Compensation) sa Estado ng California upang makakuha ng at mapanatili ang may bisang permiso upang magpatakbo ng negosyo mula sa Kagawaran ng Pampublikong Kalusugan ng San Francisco (San Francisco Department of Public Health). Sa pamamagitan nito ay pinagtitibay ko ang isa sa mga sumusunod na deklarasyon:

☐ Mayroon at magpapanatili ako ng "**Sertipiko ng Seguro (Certificate of Insurance)**" para sa seguro ng kompensasyon sa mga manggagawa, alinsunod sa Seksiyon 3700 ng Kodigo sa Paggawa (Labor Code), para sa paggawa ng trabaho kung para saan ibinigay ang permisong ito. Ang kompanya ng seguro para sa kompensasyon ng aking mga manggagawa at ang numero ng polisiya ay:

_____
Kompanya ng Seguro

_____
Numero ng Polisiya

☐ Mayroon at magpapanatili ako ng "**Sertipiko ng Pahintulot na Magkaroon ng Pansariling Seguro (Certificate of Consent to Self-Insure)**" para sa kompensasyon sa mga manggagawa, alinsunod sa Seksiyon 3700 ng Labor Code, para sa paggawa ng trabaho kung para saan ibinigay ang pahintulot na ito.

☐ Pinatutunayan ko na ang negosyong ito ay **hindi napasasailalim sa mga kinakailangan ng Seksiyon 3700 ng Labor Code** sa panahong ito. Sumasang-ayon ako na kung nangupahan ang negosyong ito ng sinumang tao sa anumang paraan kung saan mapapasailalim ito sa mga batas ng kompensasyon para sa mga manggagawa ng Estado ng California at sa mga probisyon ng Seksiyon 3700 ng Labor Code, ako ay susunod sa mga probisyong iyon at magbibigay ng katibayan ng seguro alinsunod sa atas ng San Francisco Department of Public Health.

Babala: Ang kabiguang kumuha ng seguro para sa kompensasyon ng mga manggagawa ay labag sa batas, at paparusahan ang mga kompanya o *employer* na lumabag nito ng mga parusang kriminal at mga multang sibil nang hanggang **isang daang libong dolyar ($100,000)**, dagdag pa sa halaga ng kompensasyon sa manggagawa, mga bayad-pinsala alinsunod sa Seksiyon 3706 ng Labor code, interes, at kabayaran sa abogado.

**Ako ang may-ari o awtorisadong ahente ng may-ari ng negosyong ito. Idinedeklara ko sa ilalim ng parusa sa panunumpa nang walang katotohanan na totoo at wasto ang impormasyon sa Deklarasyon ng Kompensasyon sa Mga Manggagawa na ito.**

_____ _____
Petsa Pangalan Lagda ng Aplikante

DPH Use Only: ☐ Signature Verified by ____