Department of Health & Human Services
Board of Health
212 Main Street
Northampton, MA 01060
Tel: (413) 587-1214
Commissioner: Merridith A. O'Leary, R.S.

FOR BOARD OF HEALTH USE ONLY
Date: _____
Amt Received: _____
Cash/Check No: _____
Received by: _____
Workers Comp Affidavit ☐
CPR Certification ☐
First Aid Certification ☐
Float Sign Off ☐
Collector's Approval ☐

2026 FLOTATION THERAPY ESTABLISHMENT PERMIT APPLICATION

PERMIT FEE: $250.00 ANNUAL ALL FEES PAID ARE NON-REFUNDABLE

NO PERMITS WILL BE ISSUED IF TAXES ARE OWED

Pursuant to MGL Chapter 62C, section 49A, I certify under the penalties of perjury that, to my best knowledge and belief, complied with the law of the Commonwealth relating to taxes, reporting of employees and contractors, and withholding and remitting child support.

Application is hereby made for a permit to operate a special purpose pool. This special purpose pool is to be operated according to the minimum standards of 105 CMR 435.000 Chapter V: Minimum Standards for Swimming Pools/Special Purpose Pools & the Standards of Practice of a Flotation therapy Establishment that is set forth by the Northampton Board of Health.

Establishment Name: (dba): _____ Establishment Tel.#: _____

Establishment Address: _____

Mailing Address: _____

Email Address: _____

Applicant Name and Title: _____

Applicant Address: _____ Applicant Telephone #: _____

Owner Name & Title (if different from applicant): _____

Owner Address: _____

REQUIRED-CPR AND FIRST AID FOR ALL STAFF

Please include a copy of CPR and First Aid Certification (s) with this permit and list staff below:

_____

_____

Water Source: □ Public □ Well Sewage Disposal: □ Public □ Well

Number of Flotation Tanks	
Length	
Width	
Volume	
Treatment System (Kinds of Filters, ect)	
Disinfection Method (Type, capacity, ect)	
Chemical Treatment (Feeders, capacity, quantity)	

Signature of Applicant or Corporate Signature: _____

PLEASE MAKE ALL CHECKS PAYABLE TO THE CITY OF NORTHAMPTON

This form **must** be initialed and signed by the owner of the establishment applying for or renewing a Board of Health Flotation Therapy Establishment Permit.

No permit will be issued until this checklist has been initialed and signed.

Name of Establishment: _____

Owner: _____

_____**I understand** that all on-site attendants shall have a valid First Aid and CPR certificate from an approved program and shall be maintained and kept on-site for verification.

_____ **I will** provide the Northampton Health Department with proof of current First Aid and CPR certificates.

_____ **I understand** that effective means of two way communication must exist between the attendant and each float room to provide emergency assistance to the patron at all times.

____ **I understand** that a First Aid kit must be kept on-site.

____ **I understand** that an emergency telephone must be available by staff or patrons to make emergency calls.

____ **I understand** that all patrons under 17 years of age must be accompanied by an adult.

____ **I understand** that each patron will receive written and/or verbal safety use procedures to the tank.

____ **I understand** that there will be a minimum of one sign with the rules.

____ **I understand** that all design and construction must be approved by Northampton Health Department.

____ **I understand** that skimmers, drains, and general design of the flotation tank must be VGBA compliant.

____ **I understand** that the recirculation system shall operate continuously, except for when the tank is utilized during a float session.

____ **I understand** that turnover rate must allow a minimum of three turnovers between each patron.

____ **I understand** that chemical labeling, storing, mixing, and handling shall meet the requirements according to 105 CMR 435.

____ **I understand** that chemical feeders shall meet the requirements according to 105 CMR 435.

____ **I understand** water quality levels for disinfectant, pH, alkalinity, temperature, and combined chlorine when chlorine is used as the disinfectant must be measured and recorded a minimum of three times a day.

____ **I understand** that float tanks use alternative disinfection systems must have water samples submitted to a certified lab every 2 weeks for testing for Coliform, Pseudomonas and Heterotrophic Plate Count for the first 6 months and once a month thereafter or as the Health Department requires.

____ **I understand** all water sample results and daily testing logs must be maintained and available for review by the Health Department.

____ **I understand** water source shall meet the requirements according to 105 CMR 435.

____ **I understand** that all construction, installation, expansion and/or remodel will require the plans and specifications to stamped and designed by a Massachusetts Registered Professional engineer or Massachusetts Registered Sanitarian and approved by the Board of Health

____ **I understand** water levels shall be maintained according to manufacturer's instructions of the float tank.

____ **I understand** the saline solution within the tank should be completely replaced with fresh water and salt a minimum of every twelve months or if the solution becomes cloudy, exhibits an unusual odor, or has been contaminated with fecal matter or vomit.

____ **I understand** the closing criteria in 105 CMR 435 must be followed.

____ **I understand** the interior of the float tank shall be cleaned and sanitized with an approved sanitizer a minimum of once per week and as often as needed.

____ **I understand** any modifications or replacement of equipment must be approved by the Health Department prior to operation.

____ **I understan**d floors, walls, ceilings in the float room must be maintained in a clean and sanitary condition as well as any shower, or toilet room shall be maintained according to 105 CMR 435.

____ **I understand** that water heaters, ventilation, electrical equipment, and lighting shall meet the requirements in 105 CMR 435.

____ **I understand** that adequate lighting must be provided to supply sufficient visibility when cleaning and when the patrons shower, enter, or exit the float tank.

____ **I have read and understand the Standard of Practice of the City of Northampton Board of Health.**

Signature _____ Date _____

Please Print Name _____ Title _____

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
1 Congress Street, Suite 100
Boston, MA 02114-2017
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information **Please Print Legibly**

Business/Organization Name:_____

Address:_____

City/State/Zip:_____ Phone #:_____

Are you an employer? Check the appropriate box:

1. ☐ I am a employer with _____ employees (full and/ or part-time).*
2. ☐ I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
3. ☐ We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**
4. ☐ We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

Business Type (required):

5. ☐ Retail
6. ☐ Restaurant/Bar/Eating Establishment
7. ☐ Office and/or Sales (incl. real estate, auto, etc.)
8. ☐ Non-profit
9. ☐ Entertainment
10. ☐ Manufacturing
11. ☐ Health Care
12. ☐ Other _____

*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.
**If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.

Insurance Company Name:_____

Insurer's Address:_____

City/State/Zip: _____

Policy # or Self-ins. Lic. #_____ Expiration Date:_____

Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).

Failure to secure coverage as required under Section 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to $1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to $250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.

Signature:_____ Date:_____

Phone #:_____

Official use only. Do not write in this area, to be completed by city or town official.

City or Town: _____ Permit/License #_____

Issuing Authority (circle one):
1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office
6. Other _____

Contact Person:_____ Phone #:_____