



8. PROFESSIONAL LIABILITY INSURANCE COVERAGE OF AT LEAST \$250,000.00 IS REQUIRED {SDCL 35-36-21} FOR LICENSURE.

LIST YOUR INSURANCE CARRIER \_\_\_\_\_ **AND ATTACH A COPY OF THE CERTIFICATE OF INSURANCE or DECLARATION PAGE. DO NOT SEND PROOF OF YOUR ASSOCIATION MEMBERSHIP.** THAT IS NOT PROOF OF INSURANCE.

**No license will be issued without correct proof.**

9. IF YOU HOLD A VALID LICENSE FROM ANOTHER STATE TO PRACTICE MASSAGE, WHAT IS THE STATE OF LICENSURE AND **ATTACH A COPY** OF THE CURRENT LICENSE.

STATE \_\_\_\_\_

---

10. HAVE YOU EVER BEEN CONVICTED OF A FELONY OF ANY KIND, OR OF ANY CRIME, EITHER FELONY OR MISDEMEANOR, INVOLVING DISHONESTY OR MORAL TURPITUDE, OR RELATING TO THE PRACTICE OF MASSAGE?    \_\_\_\_\_ YES    \_\_\_\_\_ NO

*IF YES*, DESCRIBE THE CONVICTION(S), THE STATE, COUNTY AND DATE OF CONVICTION (ATTACH A SEPARATE PAGE IF NECESSARY). \_\_\_\_\_

---

11. HAVE ANY PROCEEDINGS EVER BEEN TAKEN AGAINST YOU IN CONNECTION WITH LICENSURE OR PRACTICE AS A MASSAGE THERAPIST, OR FOR ANY OTHER PROFESSION, WHETHER IN SOUTH DAKOTA OR ELSEWHERE?    \_\_\_\_\_ YES    \_\_\_\_\_ NO

*IF YES*, ATTACH A SEPARATE STATEMENT WITH A DETAILED DESCRIPTION OF ANY SUCH PROCEEDINGS, THE STATE AND COUNTY IN WHICH THEY OCCURRED, AND THE DATE OF SAID ACTIONS.

12. HAVE YOU EVER BEEN DISCIPLINED WITH A REPRIMAND, CENSURE, SUSPENSION, TEMPORARY SUSPENSION, PROBATION, REVOCATION OR REFUSAL TO RENEW A LICENSE IN ANY STATE?    \_\_\_\_\_ YES    \_\_\_\_\_ NO

*IF YES*, IN A SEPARATE ATTACHMENT EXPLAIN THE REASONING FOR SUCH DISCIPLINE, DESCRIBE THE EXACT DISCIPLINE, THE DATE OF THE DISCIPLINE AND WHETHER YOU HAVE RECEIVED YOUR LICENSE BACK AFTER INCIDENT.

13. DO YOU ABUSE OR ARE YOU ADDICTED TO ALCOHOL, MARIJUANA OR ANY CONTROLLED SUBSTANCE?    \_\_\_\_\_ YES    \_\_\_\_\_ NO

14. HAVE YOU EVER BEEN FOUND TO HAVE PRESCRIBED OR ADMINISTERED CONTROLLED SUBSTANCES NARCOTICS, BARBITURATES, OR OTHER POTENTIALLY HABIT FORMING SUBSTANCES WITHOUT A LICENSE TO PRESCRIBE OR ADMINISTER SUCH SUBSTANCE ACCORDING TO SOUTH DAKOTA LAW?    \_\_\_\_\_ YES    \_\_\_\_\_ NO

*IF YES*, IN A SEPARATE ATTACHMENT GIVE A DETAILED DESCRIPTION OF ANY SUCH PROCEEDINGS, THE STATE AND COUNTY YOU PARTICIPATED IN SUCH ACTIONS, AND THE DATE OF SAID ACTIONS.

15. DO YOU OWE CHILD SUPPORT ARREARAGES IN THE SUM OF \$1,000.00 OR MORE? (more, over)    \_\_\_\_\_ YES    \_\_\_\_\_ NO

IF YES TO NUMBER 15, HAVE YOU MADE SATISFACTORY ARRANGEMENTS WITH THE DEPARTMENT OF SOCIAL SERVICES FOR PAYMENT OF ANY ACCUMULATED ARREARAGES? \_\_\_\_\_ YES \_\_\_\_\_ NO

IF YOUR ANSWER TO BOTH OF THE QUESTIONS IN # 15 IS YES, ATTACH A COPY OF THE DOCUMENT VERIFYING PAYMENT ARRANGEMENTS HAVE BEEN MADE.

16. DO YOU AGREE TO DEMONSTRATE PROFESSIONAL CONDUCT AT ALL TIMES IF LICENSED AS A MASSAGE THERAPIST? \_\_\_\_\_ YES \_\_\_\_\_ NO

**BY MY SIGNATURE BELOW, I VERIFY, UNDER PENALTY OF PERJURY, THAT I AM THE APPLICANT AND THAT ALL INFORMATION SUBMITTED ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER UNDERSTAND THAT FALSE OR INCORRECT INFORMATION, OMISSIONS, INACCURACIES OR FAILURES TO MAKE FULL DISCLOSURES MAY RESULT IN THE CANCELLATION OF OR DENIAL OF A LICENSE ISSUED PURSUANT TO THIS APPLICATION AND MAY BE SUBJECT TO CIVIL AND CRIMINAL PROCEEDINGS. I AGREE ALL INFORMATION IN THIS APPLICATION CAN BE VERIFIED AND INVESTIGATED. I HAVE READ, AND AM FAMILIAR WITH THE SOUTH DAKOTA CODIFIED LAWS REGULATING MASSAGE THERAPY AND HEREBY AGREE TO ABIDE BY SUCH LAWS.**

**Please sign in the presence of a Notary Public.**

\_\_\_\_\_  
DATE

\_\_\_\_\_  
APPLICANT SIGNATURE

STATE OF \_\_\_\_\_ )  
COUNTY OF \_\_\_\_\_ ) SS

ON THIS \_\_\_\_\_ DAY OF \_\_\_\_\_, \_\_\_\_\_, BEFORE ME, THE ABOVE APPLICANT \_\_\_\_\_ PERSONALLY APPEARED, KNOWN TO ME OR SATISFACTORILY PROVEN TO BE THE PERSON WHOSE NAME IS SUBSCRIBED TO THE WITHIN INSTRUMENT, AND ACKNOWLEDGED THAT SHE/HE EXECUTED THE SAME FOR THE PURPOSES THEREIN CONTAINED. IN WITNESS WHEREOF, I HAVE HEREUNTO SET MY HAND AND OFFICIAL SEAL.

(SEAL) \_\_\_\_\_, NOTARY PUBLIC  
NOTARY PRINT NAME: \_\_\_\_\_  
MY COMMISSION EXPIRES: \_\_\_\_\_

***DID YOU REMEMBER THE FOLLOWING:***

- ✓ *Did you attach a \$100 **money order or cashiers check** made payable to SD Board of Massage Therapy for the application fee?(no personal checks accepted)*
- ✓ *Did you enclose a clear copy of your driver's license?*
- ✓ *Did you sign and date the application in front of a Notary Public?*
- ✓ *Did you enclose your Certificate of Insurance (not association membership info)?*
- ✓ *Did you order all the items required within the application:*
  - *Official proof of passing national examination (not your national certificate)?*
  - *Instructor-completed Verification of Education with official transcripts?*

# SOUTH DAKOTA BOARD OF MASSAGE THERAPY

PO Box 1062

Sioux Falls, South Dakota 57101-1062

605/271-7103

[www.massage.sd.gov](http://www.massage.sd.gov)

## VERIFICATION OF EDUCATION FORM

**Verification must be completed & signed by the school President or Program Director and submitted with official transcripts.**

### PLEASE PRINT & PROVIDE ALL INFORMATION REQUESTED

Name of Applicant/Student: \_\_\_\_\_

#### SCHOOL

1. Name: \_\_\_\_\_

2. Address: \_\_\_\_\_

3. Qualifications

The school named above meets one of the following (*check one & provide official proof*):

licensed or approved by the State board of massage therapy where that training facility is located; **OR**

Accredited by one of the following:

Commission on Massage Therapy Accreditation (COMTA);

Accrediting Council for Independent Colleges and Schools (ACICS);

National Accrediting Commission of Career Arts & Sciences (NACCAS);

Accrediting Council for Continuing Education and Training (ACCET);

Accrediting Commission of Career Schools and Colleges (ACCSCT);

Accrediting Commission of the Distance Education and Training Council (DETC);

Higher Learning Commission (HLC).

Other: \_\_\_\_\_

4. Date of Admission: \_\_\_\_\_

Date of Completion: \_\_\_\_\_

Date of Graduation: \_\_\_\_\_

Credential Award: \_\_\_\_\_

#### Subject

(In-class instructor supervised coursework)

#### Hours of Classroom Instruction

(1 credit equals 10 hrs of classroom instruction)

Subject (In-class instructor supervised coursework)	Hours of Classroom Instruction (1 credit equals 10 hrs of classroom instruction)
Human Anatomy, Physiology, and Kinesiology (To include all 11 systems of the human body) • Minimum of 125 hours required.	- Document Hours -
Clinical Pathology and recognition of various conditions • Minimum of 40 hours required.	
Massage/Bodywork Theory, Assessment and Application • Minimum of 200 hours required.	
Adjunct techniques & methods that theoretically complete a massage program • Minimum of 125 hours required.	
Business Practices and Professionalism • Minimum of 10 hours total (to include 6 clock hours of ethics) required.	# of Ethics Hrs
Other:	
<b>TOTAL HOURS:</b>	

- more, over -

**Verification must be completed & signed by the school President or Program Director and can be sent directly to the SD Board of Massage Therapy or provided to the Applicant/Student in a sealed envelope along with office transcripts.**

*I hereby certify that to the best of my knowledge and belief, the foregoing is a true statement of the record of the individual named on this form.*

[SDBMT reserves the right to request additional documentation or further evidence of academic accomplishments.]

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title / Position: \_\_\_\_\_

Phone: \_\_\_\_\_

Date: \_\_\_\_\_

**SEAL**  
*(if applicable)*