South Dakota Board of Massage Therapy
1103 Park Hill Drive, Rapid City, SD 57701
Phone: 605-858-1708 Fax: 605-653-3879

E-mail: sdbomt@gmail.com website: doh.sd.gov/boards/Massage/

APPLICATION FOR LICENSE

Please submit the following with the completed application:

1. Please include a personal check, cashier's check, certified check or money order made payable to the State of South Dakota for the applicable amount
   a. Nonrefundable application fee of $75.
   b. Licensing fee of $45 (refundable if application is denied).
2. Copy of applicant's birth certificate or driver's license.
3. Copy of applicant's social security card.
4. Verification of any name change by applicant (marriage, divorce, etc.)
5. Quality color photograph of applicant.
6. Copy of Malpractice or Professional Liability Insurance of at least $250,000

Please have the following items submitted on behalf of the applicant:

7. Proof of applicant's passing score on an accepted nation certification exam.
   a. Results mailed directly to the board (See section 4. Education)
8. Proof of at least 500 hours of specific training in massage therapy by applicant (See section 4. Education)
   a. Completed Verification of Education Form mailed directly to the board
   b. Official Transcript mailed directly to the board
9. A verification letter from each state where licensed, along with a copy of license (See section 8. Other Licenses)

Attach Photo Here

For identification purposes, the applicant shall furnish one color headshot taken not more than six months before the date of application.

Any application will expire if pending for 12 months and the licensing fee will be forfeited.

1. APPLICANT INFORMATION		
Full Name:		
first	middle	last
List any name(s) by which you have been known in the past including nicknames, maiden name etc. *(first, middle, last)*		
☐ I have been known by no other names	***If necessary provide additional names on a separate sheet***	
		☐ Maiden Name
Address		
City	State	Zip
Cell Phone ☐ None	Home Phone	☐ None
Date of Birth	Social Security Number	

2. **COMMUNICATION**		
The Board uses e-mail to communicate with licensees		
E-mail		
Do you prefer to receive your license mailed from the Board at your:	☐ Home	☐ Primary Business
Would you like to receive mailings about continuing education opportunities from third parties?	☐ Yes	☐ No

For Office Use Only: *Date Received*: _____ By _____

Name:

3. EMPLOYMENT INFORMATION		
Do you have a business address? ☐ Yes ☐ No		
Name of Business	Phone	
Physical Address		
Mailing Address		☐ Same as above
City	State	Zip
Do you have another business address? ☐ Yes ☐ No ***If yes, please provide additional contact information on a separate sheet.***		

4. EDUCATION		
Have you completed at least 500 hours of specific training in the practice of massage therapy? ☐ Yes ☐ No		
Name of Facility(s) where completed:		
City	State	Date of Completion
A completed Verification of Education Form and official transcripts are to be mailed from the facility/school directly to the Board. ***The Verification of Education Form is attached or can be found on the website at doh.sd.gov/boards/massage/apps***		

5. NATIONAL EXAMINATION		
Please indicate which of the following licensure examination you have passed or plan to take		
Name of Examination	Date Passed	
□ **MBLEX** (FSMTB)		☐ Plan to take
□ **NBCA Massage Therapy Certification Exam** (AMMA)		☐ Plan to take
□ **NESCL** (NCBTMB)		☐ Plan to take
□ **NCETMB** (NCBTMB)		☐ Plan to take
□ **NCETM** (NCBTMB)		☐ Plan to take
Please provide official proof <u>sent directly</u> from the exam service <u>to</u> the Board. Copies will not be accepted		

6. PROOF OF MALPRACTICE OR PROFESSIONAL LIABILITY INSURANCE				
Please attach verification of your insurance coverage Certificate of Insurance or Policy Declaration Page				
Malpractice of professional liability insurance coverage of at least $250,000 is required by law (SDCL 36-35-21) for your licensure. <u>The applicant must be a named insured of the coverage</u>				
Please provide the following information for your insurance coverage. If your insurance coverage expires during the term of your massage license, you are required by law to renew it.				
Effective Date	Expiration Date	Carrier Name	Policy Number	Coverage Amount

For Office Use Only: *Date Received*: _____ By _____

Name:

7. LEGAL QUESTIONS
(if you answer YES to any question, please provide a written explanation)
Have you been convicted of or pled guilty to a felony, any crime involving or relating to the practice of massage, or any crime involving dishonesty or moral turpitude? ☐ YES ☐ NO
Have you been disciplined with a reprimand, censure, suspension, temporary suspension, probation, revocation, or refusal to renew a professional license in any state? ☐ YES ☐ NO
Are you $1,000 or more behind in child support payments? ☐ YES ☐ NO

8. OTHER LICENSES			
Have you ever held a license to practice massage therapy in another state or the District of Columbia? ☐ YES ☐ NO			
List all massage therapy licenses you have ever held (active, inactive, lapsed, etc.). Including South Dakota.			
State or Jurisdictions	License Number	Date of Licensure	Expiration Date
If you have held a license, please attach a copy of the most current license. A letter of license verification from the issuing state must be sent directly to the Board for all licenses listed.			

9. ASSOCIATIONS
Are you a member of a state massage therapy association ☐ YES ☐ NO
Are you a member of a national massage therapy association ☐ YES ☐ NO
If yes, which association? ☐ ABMP ☐ AMTA ☐ NAMT ☐ Other (please list)

10. MILITARY STATUS
Are you the spouse of a member of the armed forces of the United States ☐ Yes ☐ No
If Yes, was your spouse the subject of a military transfer to South Dakota? ☐ Yes ☐ No
If Yes, did you leave employment to accompany your spouse to South Dakota? ☐ Yes ☐ No

11. STATISTICAL INFORMATION
These questions are asked for statistical purposes. Your answers are optional.
Do you practice massage therapy ☐ Full Time ☐ Part Time ☐ Do Not Practice
What is your gender? ☐ Female ☐ Male
What is your race? Please check all that apply.
☐ Asian
☐ American Indian or Alaska Native
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ Hispanic or Latino
☐ White or Caucasian
☐ Other

For Office Use Only: *Date Received*: _____ By _____

Name:

BY MY SIGNATURE BELOW, I VERIFY, UNDER PENALTY OF PERJURY, THAT I AM THE LICENSEE COMPLETING THIS APPLICATION AND THAT ALL INFORMATION SUBMITTED IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER UNDERSTAND THAT FALSE OR INCORRECT INFORMATION, OMMISSIONS, INACCURACIES OR FAILURES TO MAKE FULL DISCLOSURE MAY RESULT IN THE CANCELLATION 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 AND ADMINISTARTIVE RULES REGULATING MASSAGE THERAPY AND HEREBY AGREE TO ABIDE BY SUCH LAWS AND REGULATIONS.

To be signed in the presence of a Notary Public

_____ _____

Signature of Applicant Date

State of _____)

)SS

County of _____)

On this _____ day of _____, 20_____, the above applicant _____personally appeared, known to me or satisfactorily proven to be the same person whose name is subscribed to the written 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 Printed Name_____

My Commission Expires _____

For Office Use Only: Check # _____*Amount* _____*Dated*_____

For Office Use Only: *Date Received*: _____ By _____

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VERIFICATION OF EDUCATION FORM

Verification of Education Form must be completed by the School President or Program Director and submitted with official transcripts directly to the SD Board of Massage Therapy.

APPLICANT/STUDENT

Name: _____
First Middle Last

SCHOOL

1. Name: _____

2. Address: _____

3. Qualifications - C***heck one and provide official proof***
   The school listed above meets one of the following criteria ***(check one and provide official proof):***
   - Licensed or approved by the State Board of Massage Therapy where that training facility is located:
     OR
   - Nationally Accredited by one of the following ***(check one and provide official proof)***
     - 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)
     - Accrediting Bureau of Health Education Schools (ABHES)
     - 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 = 10 hrs of classroom instruction**	
Human Anatomy, Physiology, and Kinesiology (to include all 11 systems of the human body) • Minimum of 125 hours required		
Clinical Pathology and recognition of various conditions • Minimum of 40 hours required		
Massage/Bodywork Theory, Assessment and Application • Minimum of 200 hours required		
Training in an area or related field that theoretically complete the massage program • Minimum of 125 hours required		
Business Practices and Professionalism • Minimum of 10 hours total required (to include 6 clock hours of ethics)		**# Ethics Hours**
Other:		
Total Hours		

For Office Use Only: Directly from school? Yes No Date Received:_____ By _____

Applicant/Student Name:

Verification must be made by the School President or Program Director. The completed Verification of Education Form can be sent directly to the South Dakota Board of Massage Therapy at 1103 Park Hill Drive, Rapid City, SD 57701 or provided to the Student/Applicant **in a sealed envelope along with official transcripts.**

To be signed in the presence of a Notary Public

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.

Signature: _____

Printed Name: _____

Title /Position: _____

Phone: _____ Date: _____

E-mail: _____

State of _____)
) SS
County of _____)

On this _____day of _____, 20__, the above _____personally appeared, known to me or satisfactorily proven to be the same person whose name is subscribed to the written 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 Printed Name _____

My Commission Expires _____

For Office Use Only: Directly from school? Yes No Date Received:_____ By _____