



# South Dakota Board of Massage Therapy

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website: [doh.sd.gov/boards/Massage/](http://doh.sd.gov/boards/Massage/)

## APPLICATION TO REACTIVATE 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. Reactivation 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
7. Proof of at least 8 hours of continuing education within the last two years

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. <i>(first, middle, last)</i> |        |   |  |
| <input type="checkbox"/> I have been known by no other names   |        | <b><i>If necessary provide additional names on a separate sheet</i></b> |  |
|  |        | <input type="checkbox"/> Maiden Name                                    |  |
| Address  |        |   |  |
| City   |        | State   | Zip                                      |
| Cell Phone   |        | <input type="checkbox"/> None   | Home Phone <input type="checkbox"/> None |
| Date of Birth  |        | Social Security Number  |  |

| 2. COMMUNICATION   |  |
|--|--|
| <b><i>The Board uses e-mail to communicate with licensees</i></b>  |  |
| E-mail   |  |
| Do you prefer to receive your license mailed from the Board at your: <input type="checkbox"/> Home <input type="checkbox"/> Primary Business             |  |
| Would you like to receive mailings about continuing education opportunities from third parties? <input type="checkbox"/> Yes <input type="checkbox"/> No |  |

| 3. EMPLOYMENT INFORMATION  |           |
|--|-----------|
| Do you have a business address? <input type="checkbox"/> Yes <input type="checkbox"/> No       |           |
| Name of Business   | Phone     |
| Physical Address   |           |
| Mailing Address <input type="checkbox"/> Same as above   |           |
| City   | State Zip |
| Do you have another business address? <input type="checkbox"/> Yes <input type="checkbox"/> No |           |
| <b><i>If yes, please provide additional contact information on a separate sheet.</i></b>       |           |

For Office Use Only:

Date Received: \_\_\_\_\_ By \_\_\_\_\_

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

**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. The applicant must be a named insured of the coverage

Please provide the following information for your insurance coverage. If you 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 |
|----------------|-----------------|--------------|---------------|-----------------|
|                |                 |              |               |                 |

**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.). Do not include 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, that have not already been sent with your previous Applications for Licensure.***

**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

For Office Use Only:

Date Received: \_\_\_\_\_ By \_\_\_\_\_

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

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

| <b>12. CONTINUING EDUCATION VERIFICATION</b>  |          |                               |                                    |              |
|---|----------|-------------------------------|------------------------------------|--------------|
| <i>Please attach verification of each course listed. You must also maintain a copy of the verification for your records for 2 years after the date of this renewal.</i>   |          |                               |                                    |              |
| <p>The South Dakota Board of Massage Therapy requires that each licensed massage therapist accumulate at least 8 hours of continuing education every two years (SDCL 36-35-19). Accepted continuing education is any course with a clear purpose and objective which maintains, improves, or expands the skills and knowledge relevant to massage therapy of the human body. Qualifying continuing education must meet the definition of massage therapy pursuant to § 36-35-1(3) or be education presented by an approved provider of the National Certification Board for Therapeutic Massage and Bodywork, American Medical Massage Association, or Federation of State Massage Therapy Boards.</p> <p>Any or all of the required 8 hours of continuing education may be obtained electronically (online or by other electronic means).</p> <p>Please list each continuing education program you are claiming in the spaces provide below. Please include a copy of the certificate of completion for all educational activities listed.</p> |          |                               |                                    |              |
| Start Date  | End Date | Title of Educational Activity | Provider Number<br>(if applicable) | Hours Earned |
|   |          |                               |                                    |              |
|   |          |                               |                                    |              |
|   |          |                               |                                    |              |
|   |          |                               |                                    |              |
|   |          |                               |                                    |              |

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, OMISSIONS, 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 ADMINISTRATIVE 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 \_\_\_\_\_*