



South Dakota Board of Massage Therapy

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www.doh.sd.gov/boards/Massage

APPLICATION FOR ANNUAL LICENSE REINSTATEMENT

Please submit the following:

1. Completed application;
2. Proof of at least 8 hours of continuing education received in the last two years;
3. Proof of Professional Liability Insurance of at least \$250,000;
4. Nonrefundable renewal fee of \$45.

This application must be submitted within 30 days of the expiration of your license. Failure to submit the application for reinstatement within 30 days of expiration will require the completion of an application of licensure to reinstate a license.

Name: _____ License Number: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Phone: _____

Name of Business: _____ Phone: _____

Physical Address: _____ Mailing address: _____

City: _____ State: _____ Zip: _____

Do you practice massage therapy: Full Time Part-Time Do Not Practice

Please answer the following questions: *If you answer yes to any question, please provide a written explanation.*

Have you ever been convicted of any felony, any crime involving or relating to the practice of massage, or any crime involving dishonesty or moral turpitude? YES NO

Have any proceedings ever been taken against you in connection with licensure or practice as a massage therapist or any licensed profession in South Dakota or any other jurisdiction? 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

Do you agree to demonstrate professional conduct at all times while licensed as a massage therapist. YES NO

Continuing Education Verification: 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.

Continuing Education Reporting
(At least 8 hours of qualifying continuing education* must be completed in the past two years.)

Date of Program	Title of Continuing Education Program	Hours Earned

*Qualifying continuing education includes education provided by an approved provider of the National Certification Board for Therapeutic Massage and Bodywork or the American Medical Massage Association or 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.

Malpractice or Professional Liability Verification: Please attach verification of your insurance coverage Certificate of Insurance or Policy Declarations Page.

Do you have malpractice or professional liability insurance coverage of at least \$250,000 in effect, as required by state law. ____ YES ____ NO

License Renewal Fee: 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.

\$45 renewal fee enclosed

BY MY SIGNATURE BELOW, I VERIFY, UNDER PENALTY OF PERJURY, THAT I AM THE LICENSEE COMPLETING THIS APPLICATION 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 FAILURE TO MAKE FULL DISCLOSURE 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.

Signature of Licensee

Date

For Office Use Only: Check # _____ Amount _____ Date _____