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 RENEWAL AFTER 9/30/2018

The South Dakota Board of Massage Therapy did not receive your application for renewal of your license by 9/30/2018, and accordingly, your licensed expired. **You are not licensed to practice massage therapy** until this application's requirements are met and your license is issued. Practicing without a valid license is subject to criminal and civil actions.

Please submit the following with the completed application:

1. Reinstatement fee of $45.00.
    a. Please include a personal check, cashier's check, certified check or money order made payable to the State of South Dakota.
2. Verification of any name change by applicant (marriage, divorce, etc.)
3. Proof of Malpractice or Professional Liability Insurance of at least $250,000 (See Section 5)
4. Proof of at least 8 hours of continuing education between October 1, 2016 and September 30, 2018. (See Section 11)

Your application for renewal will not be processed without the required fee.

Renewal applications must be postmarked by October 30, 2018.

1. APPLICANT INFORMATION		
Full Name:		
first	middle	last
License Number		
Address		
City	State	Zip
Cell Phone ☐ None	Home Phone ☐ None	

2. COMMUNICATION
The Board uses e-mail to communicate with licensees. Please add a valid e-mail address.
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 _____

For Office Use Only: Check # _____ Amount _____ Dated_____

Name:

3. PRIMARY BUSINESS		
Do you have a business address? ☐ Yes ☐ No		
Name of Primary 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	
To help verify the Board's records for our electronic database, please provide information about the school you received your massage training from and year of graduation.	
Name of School/Facility	
City	State
Year of graduation	

5. 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

6. 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

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Name:

7. OTHER LICENSES	
Do you currently hold a license to practice massage therapy in another state or the District of Columbia? ☐YES ☐ NO ***If yes, list active massage therapy licenses you currently have.***	
State or Jurisdictions	License Number

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

9. 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

10. 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	☐ Hispanic or Latino
☐ American Indian or Alaska Native	☐ White or Caucasian
☐ Black or African American	☐ Other
☐ Native Hawaiian or Pacific Islander	

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Name:

11. CONTINUING EDUCATION VERIFICATION

Please attach verification of each course listed. You must also maintain a copy of the verification for your records for 5 years after the date of this renewal.

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.

Any or all of the required 8 hours of continuing education may be obtained electronically (online or by other electronic means).

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.

Start Date	End Date	Title of Educational Activity	Provider Number (if applicable)	Hours Earned
			Total Hours	

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.

_____ _____

Signature of Applicant Date

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