



# South Dakota Board of Massage Therapy

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## 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 \$65 (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 \$250,000 000 per occurrence (See Section 7. Proof of liability insurance)
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			
License Number:			
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>	
Maiden Name		<input type="checkbox"/> N/A	
Address			
City		State	Zip
Cell Phone	<input type="checkbox"/> None	Home Phone	<input type="checkbox"/> None
Date of Birth		Social Security Number	

2. MILITARY STATUS			
Are you or your spouse an active duty member of the armed forces of the United States		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, were you or your spouse the subject of a military transfer to South Dakota?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, are you or your spouse on full-time active duty status stationed in South Dakota		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If all answers are Yes, please provide a copy of the transfer orders.			
If all answers are Yes, you are not required to pay the reactivation fee.			

3. 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

For Office Use Only:

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

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

**4. EMPLOYMENT INFORMATION**

Do you have a place of business where you perform massage? <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
<i>If you have another place of business where you perform massage, please provide additional contact information on a separate sheet.</i>		

**5. EDUCATION**

Have you completed specific training in the practice of massage therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Facility(s) where completed:		
City	State	Date of Completion
Name of Facility(s) where completed:		
City	State	Date of Completion
<i>If you have attended another facility, please provide additional information on a separate sheet.</i>		

**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 per occurrence is required by law (SDCL 36-35-21) for your licensure. The applicant must be a named insured of the coverage  
If your insurance coverage expires during the term of your massage license, you are required by law to renew it.

**8. 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? <input type="checkbox"/> YES <input type="checkbox"/> NO
Have you been disciplined with a reprimand, censure, suspension, temporary suspension, probation, revocation, or refusal to renew a professional license in any state? <input type="checkbox"/> YES <input type="checkbox"/> NO
Are you \$1,000 or more behind in child support payments? <input type="checkbox"/> YES <input type="checkbox"/> NO

**9. OTHER LICENSES**

Have you ever held a license to practice massage therapy in another state or the District of Columbia? <input type="checkbox"/> YES <input type="checkbox"/> NO			
<b><i>List all massage therapy licenses you have ever held (active, inactive, lapsed, etc.). Do not include South Dakota.</i></b>			
State or Jurisdictions	License Number	Date of Licensure	Expiration Date
<i>If you have additional licenses, please provide information on a separate sheet</i>			

For Office Use Only:

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

**10. 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)

**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

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

**12. 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 licensure.*

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.

See the course category policy identifying acceptable courses. The course category policy is located in Board Policies and Positions, pages 3 – 5, located on the home page of the website. <https://doh.sd.gov/boards/massage/>

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.

Include a copy of the certificate of completion for all educational activities listed.

Start Date	End Date	Title of Educational Activity	NCBTMB Provider Number (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 \_\_\_\_\_*