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 - AFTER TEMPORARY PERMIT(S)

Date of applicant's prior Temporary Permit was issued: _____/_____/_____

a. If the issue date is greater than one year from application date, you are not eligible to complete this form. You must complete the Application for License and pay the applicable fees.
b. If issue date is one year or less from the postmarked date, please continue.

Attach Photo Here

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

Please submit the following:

1. Licensing fee of $65 (refundable if application is denied)
2. Verification of any name change by applicant since prior permit date
3. Copy of Malpractice or Professional Liability Insurance of at least $250,000 if expired since prior permit date.

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

4. Proof of applicant's passing score on an accepted national certification exam. (See section 4. National Examination)
5. A verification letter from each state where licensed, along with a copy of license (See section 8. Other Licenses)

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 Address:		
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. 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 sent directly from the exam service to the Board. Copies will not be accepted		

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. The applicant must be a named insured of the coverage
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			
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, that have not already been sent for your Temporary Permit Application(s).			

8. 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)

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
☐ 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:

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 _____