



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

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. Nonrefundable application fee of \$100.
 - b. Licensing 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

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 have the following items submitted on behalf of the applicant:

7. Proof of applicant's passing score on an accepted nation certification exam.
 - a. Results mailed directly to the board (See section 4. Education)
8. Proof of at least 500 hours of specific training in massage therapy by applicant (See section 4. Education)
 - a. Completed Verification of Education Form mailed directly to the board
 - b. Official Transcript mailed directly to the board
9. 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. <i>(first, middle, last)</i>			
<input type="checkbox"/> I have been known by no other names		<i>If necessary provide additional names on a separate sheet</i>	
			<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	
<i>The Board uses e-mail to communicate with licensees</i>	
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: _____

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 <i>If yes, please provide additional contact information on a separate sheet.</i>		

4. EDUCATION		
Have you completed at least 500 hours of 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
<i>A completed Verification of Education Form and official transcripts are to be mailed from the facility/school directly to the Board. The Verification of Education Form is attached or can be found on the website at doh.sd.gov/boards/massage/apps</i>		

5. NATIONAL EXAMINATION		
<i>Please indicate which of the following licensure examination you have passed or plan to take</i>		
Name of Examination	Date Passed	
<input type="checkbox"/> MBLEX (FSMTB)		<input type="checkbox"/> Plan to take
<input type="checkbox"/> NBCA Massage Therapy Certification Exam (AMMA)		<input type="checkbox"/> Plan to take
<input type="checkbox"/> NESCL (NCBTMB)		<input type="checkbox"/> Plan to take
<input type="checkbox"/> NCETMB (NCBTMB)		<input type="checkbox"/> Plan to take
<input type="checkbox"/> NCETM (NCBTMB)		<input type="checkbox"/> Plan to take
<i>Please provide official proof <u>sent directly</u> from the exam service <u>to</u> the Board. Copies will not be accepted</i>		

6. PROOF OF MALPRACTICE OR PROFESSIONAL LIABILITY INSURANCE				
<i>Please attach verification of your insurance coverage Certificate of Insurance or Policy Declaration Page</i>				
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

Name: _____

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.). 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.

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

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

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 _____

Applicant/Student Name: _____

Verification must be made by the School President or Program Director. The completed Verification of Education Form can be sent directly to the South Dakota Board of Massage Therapy at 1103 Park Hill Drive, Rapid City, SD 57701 or provided to the Student/Applicant **in a sealed envelope along with official transcripts.**

To be signed in the presence of a Notary Public

I HEREBY CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE FOREGOING IS A TRUE STATEMENT OF THE RECORD OF THE INDIVIDUAL NAMED ON THIS FORM.

Signature: _____

Printed Name: _____

Title /Position: _____

Phone: _____

Date: _____

E-mail: _____

State of _____)
County of _____) SS

On this ____ day of _____, 20__, the above _____ 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 _____