



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 per occurrence (See section 7. Proof of liability insurance)

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 6 National Examination)
8. Proof of at least 500 hours of specific training in massage therapy by applicant (See section 5. 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 9. 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>	
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 application fee or the licensing fee.			

For Office Use Only:

Date Received: _____ By _____

Name: _____

3. COMMUNICATION

The Board uses e-mail to communicate with licensees

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

4. EMPLOYMENT INFORMATION

Do you have a place of business where you perform massage? Yes No

Name of Business _____ Phone _____

Physical Address

Mailing Address _____ Same as above

City _____ State _____ Zip _____

If you have another place of business where you perform massage, *please provide additional contact information on a separate sheet.*

5. EDUCATION

Have you completed at least 500 hours of specific training in the practice of massage therapy? Yes No

Name of Facility(s) where completed:

City _____ State _____ Date of Completion _____

Name of Facility(s) where completed:

City _____ State _____ Date of Completion _____

If you have attended another facility, *please provide additional information on a separate sheet.*

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

6. NATIONAL EXAMINATION

Please indicate which of the following licensure examination you have passed or plan to take

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

Please provide official proof sent directly from the exam service to the Board. Copies will not be accepted

7. 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

If your insurance coverage expires during the term of your massage license, you are required by law to renew it.

For Office Use Only:

Date Received: _____ By _____

Name: _____

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? 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

9. 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 additional licenses, please provide information on a separate sheet.

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.

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

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 _____



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VERIFICATION OF EDUCATION FORM

Verification of Education Form must be completed by the School President or Program Director and submitted with official transcripts directly to the SD Board of Massage Therapy.

APPLICANT/STUDENT

Name: _____
First Middle Last

SCHOOL

1. Name: _____

2. Address: _____

3. Qualifications - **Check one and provide official proof**

The school listed above meets one of the following criteria (***check one and provide official proof***):

____ Licensed or approved by the State Board of Massage Therapy where that training facility is located
(***provide official proof***):

OR-

Nationally Accredited by one of the following (***check one and provide official proof***)

- ____ Commission on Massage Therapy Accreditation (COMTA)
- ____ Accrediting Council for Independent Colleges and Schools (ACICS)
- ____ National Accrediting Commission of Career Arts & Sciences (NACCAS)
- ____ Accrediting Council for Continuing Education and Training (ACCET)
- ____ Accrediting Commission of Career Schools and Colleges (ACCSC)
- ____ Accrediting Commission of the Distance Education and Training Council (DETC)
- ____ Higher Learning Commission (HLC)
- ____ Accrediting Bureau of Health Education Schools (ABHES)
- ____ Other: _____

4. Date of Admission: _____ Date of Completion: _____

Date of Graduation: _____ Credential Award: _____

Applicant/Student Name: _____

Subject (1 credit = 10 hours of instructions)	In Class instructor supervised coursework	Instructor supervised hands on coursework	Total Hours of Instruction
Human Anatomy, Physiology, and Kinesiology (to include all 11 systems of the human body) <ul style="list-style-type: none"> • Minimum of 125 hours required 			
Clinical Pathology and recognition of various conditions <ul style="list-style-type: none"> • Minimum of 40 hours required 			
Massage/Bodywork Theory, Assessment and Application <ul style="list-style-type: none"> • Minimum of 200 hours required 			
Training in an area or related field that theoretically complete the massage program <ul style="list-style-type: none"> • Minimum of 125 hours required 			
Business Practices and Professionalism <ul style="list-style-type: none"> • Business Practices and Professionalism including Ethics - Minimum of 10 hours 			
Ethics <ul style="list-style-type: none"> • Minimum of 6 hours required 			
Other:			
Total Hours			
		Minimum of 200 hours required	Minimum of 500 hours required

Applicant/Student Name: _____

Verification must be made by the School President or Program Director. The completed Verification of Education Form must be sent directly to the South Dakota Board of Massage Therapy at 1103 Park Hill Drive, Rapid City, SD 57701

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 _____