South Dakota Board of Massage Therapy
Location: 217 W Missouri Ave, Pierre, SD 57501
Mailing: 217 W Missouri Ave, Pierre, SD 57501
Phone: 605-773-3440 Fax: 605-773-7175

E-mail: massagetherapy@state.sd.us website: doh.sd.gov/boards/Massage/

2022 APPLICATION FOR LICENSE RENEWAL

Please submit the following with the completed application by mail (or login on our website to complete online):

1. Renewal fee of $65.00.
   a. Please include a personal check, cashier's check, certified check, or money order made payable to the South Dakota Board of Massage Therapy. *Cash payments will not be accepted.*
      i. Checks will be processed as a one-time electronic funds transfer from the coinciding account.
2. Proof of Malpractice or Professional Liability Insurance of at least $250,000 (see Section 7)
3. Proof of at least 8 hours of Continuing Education (see Section 8)

Your application for renewal will not be processed without the required fee or documents above.
All renewal applications must be postmarked by September 30, 2022, or your license will be considered expired, and you may not work until you reapply for licensure.

1. **APPLICANT INFORMATION**		
Full Name:		
(as it appears on your license) first	middle	last
License Number: MT		
Address:		Apt/Unit/Suite #:
City:	State:	Zip:
Cell Phone: ☐ *None*	Home Phone: ☐ *None*	

1B. **NAME CHANGE (if applicable)**		
Is your legal name different than the name on your license? ☐ Yes ☐ No		
Full Legal Name:		
first	middle	last
Please include a copy of the legal document which initiated the name change – marriage certificate, divorce decree, adult adoption agreement, etc. Without proof, the name change cannot be applied.		

2. **MILITARY STATUS**		
Are you or your spouse of a member of the armed forces of the United States? (if "no", skip to Section 3)	☐ Yes	☐ No
If "yes", were you or your spouse the subject of a military transfer to South Dakota	☐ Yes	☐ No
If "yes", did you leave employment to accompany to relocate to South Dakota?	☐ Yes	☐ No
If all answers are "yes", please provide a copy of the transfer orders (AF Form 899) and a copy of your military ID card – front and back. If these documents are provided, the renewal fee will be waived.		

For Office Use Only: *Date Received*: _____ By _____

Check #: _____ *Amount:* _____ *Dated:* _____

3. **COMMUNICATION**
The Board uses e-mail to communicate with licensees. Please add a valid e-mail address.
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, employment, or other opportunities from third parties? ☐ Yes ☐ No

4. **PRIMARY BUSINESS**		
Do you have a business address? ☐ Yes ☐ No (if "no", skip to Section 5)		
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.***		

5. **LEGAL QUESTIONS**
(if you answer "yes" to any question, please provide a written explanation)
Have you been convicted of, or pled guilty or *nolo contendere* to, a felony, any crime involving or relating to the practice of massage, or any crime involving dishonesty or moral turpitude since your last renewal that has not been reported to the Board? ☐ 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 in the past twelve months that has not been reported to the Board? ☐ Yes ☐ No
Are you $1,000 or more behind in child support payments? ☐ Yes ☐ No

6. **OTHER LICENSES**		
Do you currently hold a license to practice massage therapy in another state or District of Columbia? ☐ Yes ☐ No ***If "yes", list active massage therapy licenses you currently have.***		
State	**License Number**	**Expiration Date**

7. **PROOF OF MALPRACTICE OR PROFESSIONAL LIABILITY INSURANCE**
Please attach verification of your insurance coverage Certificate of Insurance or Policy Declaration Page.
Malpractice or 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.

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8. CONTINUING EDUCATION

Please attach completion certificates or proof of each course listed. You must maintain a copy of each verification of completion for your records for 5 years per Administrative Rule 20:76:03:05.

Licensed massage therapists must complete at least 8 hours of Continuing Education every two years by law (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 (NCBTMB), American Medical Massage Association (AMMA), or Federation of State Massage Therapy Boards (FSMTB) (ARSD 20:76:03:04).

The course must also comply with FSMTB's Course Category Policy (Board Action September 25, 2019).

Any or all of the required 8 hours of Continuing Education may be obtained electronically, in-person, or a mixture of both.

Please list each Continuing Education program you are claiming that was held between ***October 1, 2020*** and ***September 30, 2022*** in the spaces provided below. Please provide any additional course information on a separate sheet. If you were licensed during this Continuing Education cycle, please reference the proration chart on our website to see how many of the 8 hours you are required to complete.

You must include a copy of the certificate of completion for all listed courses.

Start Date	End Date	Title of Course	Provider/Approval Number *(if applicable)*	Hours Earned

By my signature below, I verify, under penalty of perjury, that I am the licensee completing this application and 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 that 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.

_____ _____

Signature of Applicant **Date**

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