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 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
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. *(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		
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

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.***		

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

Name:

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

Effective Date	Expiration Date	Carrier Name	Policy Number	Coverage Amount

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.). Do not include 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 with your previous Applications for Licensensure.			

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

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

Name:

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			

12. CONTINUING EDUCATION VERIFICATION

Please attach verification of each course listed. You must also maintain a copy of the verification for your records for 2 years after the date of this renewal.

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.

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

Start Date	End Date	Title of Educational Activity	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, 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 _____