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 $250,000 000 per occurrence (See Section 7. Proof of liability insurance)
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		☐ N/A
Address		
City	State	Zip
Cell Phone ☐ None	Home Phone	☐ 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	☐ Yes	☐ No
If Yes, were you or your spouse the subject of a military transfer to South Dakota?	☐ Yes	☐ No
If Yes, are you or your spouse on full-time active duty status stationed in South Dakota	☐ Yes	☐ 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 reactivation fee.		

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

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

Name:

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 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.*		

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 per occurrence is required by law (SDCL 36-35-21) for your licensure. <u>The applicant must be a named insured of the coverage</u>
If your insurance coverage expires during the term of your massage license, you are required by law to renew it.

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.). Do not include South Dakota.			
State or Jurisdictions	License Number	Date of Licensure	Expiration Date
If you have additional licenses, please provide information on a separate sheet			

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Name:

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

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12. CONTINUING EDUCATION VERIFICATION

Please attach verification of each course listed. You must also maintain a copy of the verification for your records for 5 years after the date of this licensure.

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.

See the course category policy identifying acceptable courses. The course category policy is located in Board Policies and Positions, pages 3 – 5, located on the home page of the website. https://doh.sd.gov/boards/massage/

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.

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

Start Date	End Date	Title of Educational Activity	NCBTMB 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 _____