



# South Dakota Board of Massage Therapy

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## APPLICATION FOR 2020 LICENSE RENEWAL

Please submit the following with the completed application:

1. Renewal fee of \$65.00.  
Include a personal check, cashier's check, certified check or money order made payable to the State of South Dakota. DO NOT SEND CASH
  - a. The Board may use information from the check(s) to initiate a one-time debit electronic funds transfer from the bank account
2. Proof of Malpractice or Professional Liability Insurance of at least \$250,000 per occurrence (See Section 7)
3. Proof of at least 8 hours of continuing education between October 1, 2018 and September 30, 2020. (See Section 11)

***Your application for renewal will not be processed without the required fee.  
All renewal applications must be postmarked by September 30, 2020.***

1. APPLICANT INFORMATION			
Full Name:			
first	middle	last	
License Number			
Address			
City	State	Zip	
Cell Phone	<input type="checkbox"/> None	Home Phone	<input type="checkbox"/> None

1B. NAME CHANGE		
Is your legal name different than the name on your license? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no skip to section 2)		
New Name		
first	middle	last
<i>Please submit proof of the name change. Proof can be a copy of your marriage license, divorce decree or other legal documents noting the change. You may also use a copy of your SD issued driver's license or identification card.</i>		

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 (AF Form 899) and a copy of your military ID card – front and back. You are not required to pay the renewal fee.	

For Office Use Only:

Date Received: \_\_\_\_\_ By \_\_\_\_\_

Name: \_\_\_\_\_

**3. COMMUNICATION & MAILINGS**

***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                      OR                       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 \_\_\_\_\_

Same as home address

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_

Same as above

Same as home address

City \_\_\_\_\_

State \_\_\_\_\_

Zip \_\_\_\_\_

Do you have another business address?     Yes     No

***If yes, please provide additional contact information on a separate sheet.***

**5. EDUCATION**

To help verify the Board's records for our electronic database, please provide information about the school you received your massage training from and year of graduation.

Name of School/Facility \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Year of graduation \_\_\_\_\_

**6. 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 no skip to section 7)

If yes, which association?     ABMP     AMTA     NAMT     Other (please list)

Name: \_\_\_\_\_

**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 per occurrence is required by law (SDCL 36-35-21) for your licensure. The applicant must be a named insured of the coverage

**The insurance policy submitted provides coverage for me, as a named insured, in the amount stated. I further certify that I am aware of the requirement to maintain malpractice insurance in at least the amount of \$250,000 per occurrence and such insurance shall be renewed by me if it expires during the term of my massage therapy license**

\_\_\_\_\_ Initials

**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 in the past twelve months or 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 or that has not been reported to the board?

YES  NO

Are you \$1,000 or more behind in child support payments?

YES  NO

**9. OTHER LICENSES**

Do you currently hold a license to practice massage therapy in another state or the District of Columbia?

YES  NO *If yes, list active massage therapy licenses you currently have.*

State or Jurisdictions	License Number

*Please provide any additional license information on a separate sheet*

Name: \_\_\_\_\_

10. STATISTICAL INFORMATION			
<i>These questions are asked for statistical purposes. Your answers are optional.</i>			
Do you practice massage therapy	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Do Not Practice
What is your gender?	<input type="checkbox"/> Female	<input type="checkbox"/> Male	
What is your race? Please check all that apply.			
<input type="checkbox"/> Asian		<input type="checkbox"/> Hispanic or Latino	
<input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> White or Caucasian	
<input type="checkbox"/> Black or African American		<input type="checkbox"/> Other	
<input type="checkbox"/> Native Hawaiian or Pacific Islander			

11. CONTINUING EDUCATION VERIFICATION
<i>Please attach verification of each course listed. You must also maintain a copy of the verification for your records for 5 years..</i>
Licensed massage therapists must complete at least 8 hours of continuing education every two years. ( <a href="#">SDCL 36-35-19</a> ) 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. ( <a href="#">ARSD 20:76:03</a> ) <b>AND The course must comply with the Course Category Policy (Board Action September 25, 2019) The Policy can be found in the Continuing Education section of the website. <a href="https://doh.sd.gov/boards/massage/continuinged.aspx">https://doh.sd.gov/boards/massage/continuinged.aspx</a></b>
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 that was held between <b>October 1, 2018 and September 30, 2020</b> 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 or Approval Number (if applicable)	Hours Earned

*Please provide any additional course information on a separate sheet(s)*

Name: \_\_\_\_\_

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, inaccurate 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

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

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*For Office Use Only: Check #* \_\_\_\_\_ *Amount* \_\_\_\_\_ *Dated* \_\_\_\_\_