



South Dakota Board of Massage Therapy

Location: 221 W Capitol Ave Suite 101

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

APPLICATION FOR LICENSE RENEWAL

Please submit the following with the completed application:

1. Renewal fee of \$65.00.
 - a. Please include a personal check, cashier's check, certified check or money order made payable to the State of South Dakota.
 - i. The Board may use information from the check(s) to initiate a one-time debit electronic funds transfer from the bank account
2. Verification of any name change by applicant (marriage, divorce, etc.)
3. Proof of Malpractice or Professional Liability Insurance of at least \$250,000 (See Section 5)

***Your application for renewal will not be processed without the required fee.
All renewal applications must be postmarked by September 30, 2021.***

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

2. COMMUNICATION	
<i>The Board uses e-mail to communicate with licensees. Please add a valid e-mail address.</i>	
E-mail Address:	
Do you prefer to receive your license mailed from the Board at your:	<input type="checkbox"/> Home <input type="checkbox"/> Primary Business
Would you like to receive mailings about continuing education, employment or other opportunities from third parties?	
Yes	No <input type="checkbox"/> <input type="checkbox"/>

3. PRIMARY BUSINESS	
Do you have a business address? <input type="checkbox"/> Yes <input type="checkbox"/> No (if no skip to section 4)	
Name of Primary Business	Phone
Physical Address	
Mailing Address as above	<input type="checkbox"/> Same
City	State Zip
Do you have another business address? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If yes, please provide additional contact information on a separate sheet.</i>	

For Office Use Only: Date Received: _____ By _____
Check # _____ Amount _____ Dated _____

Name: _____

4. 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

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

Effective Date	Expiration Date	Carrier Name	Policy Number	Coverage Amount

6. 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

7. 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

Name: _____

8. ASSOCIATIONS	
Are you a member of a state massage therapy association	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you a member of a national massage therapy association	<input type="checkbox"/> YES <input type="checkbox"/> NO (if no skip to section 9)
If yes, which association?	<input type="checkbox"/> ABMP <input type="checkbox"/> AMTA <input type="checkbox"/> NAMT <input type="checkbox"/> Other (please list)

9. MILITARY STATUS	
Are you the spouse of a member of the armed forces of the United States	<input type="checkbox"/> Yes <input type="checkbox"/> No (if no skip to section 10)
If Yes, was your spouse the subject of a military transfer to South Dakota?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, did you leave employment to accompany your spouse to South Dakota?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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
<p>Licensed massage therapists must complete 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. (ARSD 20:76:03)</p> <p>Any or all of the required 8 hours of continuing education may be obtained electronically (online or by other electronic means).</p> <p>Continuing education requirements must be met every two years. The current continuing education cycle runs from October 1, 2020 through September 30, 2022. Continuing education used to meet renewal requirements must be taken during the current continuing education cycle.</p> <p>Because continuing education is required every two years, continuing education is prorated based on the initial date of your licensure. If you were licensed before October 1, 2020, you must show proof of 8 hours of continuing education to renew your license by September 30, 2022. If you were licensed after October 1, 2020, please refer to the following for the continuing education hours required to renew your license by September 30, 2022:</p> <ul style="list-style-type: none">• October 1, 2020 – March 31, 2021• April 1, 2021 – September 30, 2021• October 1, 2021 – March 31, 2022• April 1, 2022 – May 31, 2022• 8 hours of continuing education required• 6 hours of continuing education required• 4 hours of continuing education required• 2 hours of continuing education required <p>Continuing education is not required to renew your license this year, but will be required to renew your license in 2022.</p> <p><i>Initial that you have read the requirements for continuing education and are aware of the continuing education requirements you will need to meet to renew your license in 2022.</i></p> <p style="text-align: right;">_____</p> <p style="text-align: right;">Initials</p>

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