South Dakota Board of Massage Therapy
1601 N Harrison Ave Ste 6 ● Pierre SD 57501
Phone: 605-295-8590

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

APPLICATION FOR 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. Nonrefundable application fee of $100.
   b. Licensing fee of $65 (refundable if application is denied).
2. Copy of applicant's birth certificate or driver's license (front only)
3. Copy of applicant's social security card (front only)
4. Verification of any name change by applicant (marriage, divorce, etc.)
5. Quality color photograph of applicant (from past six months)
6. Copy of Malpractice or Professional Liability Insurance of at least $250,000 per occurrence (See section 7. Proof of malpractice of professional liability insurance)

Attach Photo Here

For identification purposes, the applicant shall furnish one color headshot taken not more than six months before the date of application.

Please have the following items submitted on behalf of the applicant:

7. Proof of applicant's passing score on an accepted national competency exam.
   a. Results emailed directly to the board (See section 6. National Examination)
8. Proof of at least 500 hours of specific training in massage therapy by applicant (See section 5. Education)
   a. Completed Verification of Education Form mailed or emailed directly to the board
   b. Official Transcript mailed or emailed directly to the board
9. A verification letter from each state or jurisdiction where licensed – email preferred (See section 9. Other Licenses)

Any application will expire if pending for 12 months and the licensing fee will be forfeited.

1. APPLICANT INFORMATION		
Full Name:		
first	middle	last
Have you have been known by any other name including nicknames, maiden name etc. *(first, middle, last)*? ☐ No ☐ Yes (if yes, list below)		
If necessary provide additional names on a separate sheet		
Date of Birth		
Gender ☐ Female ☐ Male		
Social Security Number		
Home Address		
City	State	Zip
Cell Phone ☐ None		
Home Phone ☐ None		
The Board uses e-mail to communicate with licensees (Please print legibly)		
E-mail		

For Office Use Only: *Date Received*: _____

Name of Applicant:_____

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 application fee or the licensing fee.		

3. COMMUNICATION
Please note, the Board uses e-mail to communicate with licensees
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 and employment opportunities from third parties? ☐ Yes ☐ No

4. EMPLOYMENT INFORMATION		
Do you (or will you) perform massage at a place of business? ☐ No ☐ at Home ☐ Yes ☐ Yes, once licensed (if yes or yes once licensed, complete information below)		
Primary 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 at least 500 hours of specific training in the practice of massage therapy? ☐ Yes ☐ No List all facilities/school(s) you have attended to obtain training in the practice of massage therapy.		
Name of Facility:		
City	State	Date of Completion
Name of Facility:		
City	State	Date of Completion
If you have attended another facility, please provide additional information on a separate sheet.		
A completed Verification of Education Form and official transcripts are to b mailed or emailed from each of the facility/school(s) directly to the Board. The Verification of Education Form can be found on the website at doh.sd.gov/boards/massage/apps		

Name of Applicant:_____

6. NATIONAL EXAMINATION		
Please indicate which of the following licensure examination you have passed or plan to take		
Name of Examination	Date Passed	
□ **MBLEX** (FSMTB)		☐ Plan to take
□ **NBCA Massage Therapy Certification Exam** (AMMA)		☐ Plan to take
□ **NESCL** (NCBTMB)		☐ Plan to take
□ **NCETMB** (NCBTMB)		☐ Plan to take
□ **NCETM** (NCBTMB)		☐ Plan to take
Please provide official proof <u>sent directly</u> from the exam service <u>to</u> the Board. Copies will not be accepted		

7. PROOF OF MALPRACTICE OR PROFESSIONAL LIABILITY INSURANCE
Please attach verification of your insurance coverage -- Certificate of Insurance (first page only)
Malpractice or 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)

1. Have you been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or adjudication, suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense, other than minor traffic violations? _____YES _____NO

If YES, provide a signed and dated explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.

2. Is there any pending charge(s) against you with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? _____YES _____NO

3. Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you? _____YES _____NO

4. Has any massage therapy license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action? _____YES _____NO

5. Have you had privileges revoked, reduced, or otherwise restricted at any healthcare provider entity? _____YES _____NO

6. Have you been treated for abuse or misuse of any alcohol or chemical substance? _____YES _____NO

7. Are you currently enrolled in an Alternative to Discipline Program? _____YES _____NO

8. Have you experienced a physical, emotional, or mental condition that has endangered or posed a direct threat to the health or safety of persons entrusted to your care or your ability to safely practice? _____YES _____NO

9. Do you currently owe child support arrearages in the sum of $1,000 or more? _____YES _____NO

For 2-9 above, provide an explanation for each YES response on a separate piece of paper, with a complete description of dates and circumstances. You must also send ALL supporting applicable documents.

Name of Applicant:_____

9. OTHER LICENSES			
Have you ever held a license to practice massage therapy in another state or jurisdiction? ☐ YES ☐ NO (If you answer yes, complete the information below)			
List all massage therapy licenses you have ever held (active, inactive, lapsed, etc.). Including South Dakota.			
State or Jurisdiction	License Number	Date of Licensure	Expiration Date
If you have additional licenses, please provide information on a separate sheet.			
If you have held a license, attach a copy of the most current license. A letter of license verification from the issuing state or jurisdiction must be sent directly to the Board for all licenses listed.			

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 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

Name of Applicant:_____

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 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 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.

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: *Date Received*: _____