

South Dakota Board of Massage Therapy

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2024 APPLICATION FOR LICENSE RENEWAL

Please submit the following with the completed application by mail (or login on our website to complete online):

- 1. Renewal fee of \$65.00.
 - a. Please include a personal check, cashier's check, certified check, or money order made payable to the South Dakota Board of Massage Therapy. *Cash payments will not be accepted*.
 - i. Checks will be processed as a one-time electronic funds transfer from the coinciding account.
- 2. Proof of Malpractice or Professional Liability Insurance of at least \$250,000 (see Section 7)
- 3. Proof of at least 8 hours of Continuing Education (see Section 8)

Your application for renewal will not be processed without the required fee or documents above. All renewal applications must be postmarked by September 30, 2024, or your license will be considered expired, and you may not work until you reapply for licensure.

1. APPL	ICANT INFORMATION				
Full Name:					
(as it appears on your license) first	middle	last			
License Number: MT					
Address:		Apt/Unit/Suite #:			
City:	State:	Zip:			
Cell Phone:	ne Home Phone:	☐ None			
	1				
1B. NA	ИЕ CHANGE (if applicable	e)			
Is your legal name different than the name on your license?					
Full Legal Name:					
first	middle	last			
Please include a copy of the legal document which	h initiated the name chang	e – marriage certificate, divorce			
decree, adult adoption agreement, etc. V	Vithout proof, the name ch	ange cannot be applied.			
2. N	/ILITARY STATUS				
Are you or your spouse of a member of the armed		☐ Yes ☐ No			
,	skip to Section 3)	Dalvata Vas Na			
If "yes", were you or your spouse the subject of a	i mintary transfer to South I	Dakota Yes No			
If "yes", did you leave employment to accom	npany to relocate to South D	Oakota? Yes No			
If all answers are "yes", please provide a copy of the tr					
front and back. If these documents	are provided, the renewal fee	will be waived.			
For Office Use Only: Date of the Date of t	te Received:	By			
Check #:	Amount:	Dated:			

	3. CO I	MMUNICATION		
The Board uses e-mail to comm	nunicate wi	th licensees. Ple	ase add a va	lid e-mail address.
E-mail Address:				
Do you prefer to receive your license n	nailed from the	Board at your:	Home	Primary Business
Would you like to receive mailings abordarties? Yes No	out continuing	education, employr	ment, or other o	pportunities from third
	4. PRIN	MARY BUSINESS		
Do you have a business address?	Yes	No (if "no", sk	ip to Section 5)	
Name of Primary Business:			Phone:	
Physical Address:				
Mailing Address: Same as above				
City:		State:		Zip:
Do you have another business address? If "yes", please provide addition	_	No No	narate sheet	1 - 7
ij yes , pieuse provide additi	onai comaci ii	ijormanon on a sej	paraie sneei.	
/*F		AL QUESTIONS	**** 1	· \
(if you answer "yes" Have you been convicted of, or pled gu				
the practice of massage, or any crime in				
not been reported to the Board?	Yes \square	No	reace since you	i last followar that has
Have you been disciplined with a reprin	mand. censure.	suspension, tempo	prary suspension	n. probation, revocation,
or refusal to renew a professional licen Board? Yes No				
Are you \$1,000 or more behind in child	d support paym	nents? Yes	□ No	
	11 1 7			
		HER LICENSES		
Do you currently hold a license to prac				
		<i>nassage therapy lic</i> cense Number	` ,	
State	Lie	cense Number		Expiration Date
_				_
7. PROOF OF MA	LPRACTICE O	R PROFESSIONAL	LIABILITY INS	SURANCE
Please attach verification of your in	surance cover	age Certificate of I	nsurance or Po	licy Declaration Page.
Malpractice or professional liability in 21) for your licensure.				
For Office Use Only:	Date	Received:		By

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8. CONTINUING EDUCATION

Please attach completion certificates or proof of each course listed. You must maintain a copy of each verification of completion for your records for 5 years per Administrative Rule 20:76:03:05.

Licensed massage therapists must complete at least 8 hours of Continuing Education every two years by law (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 (NCBTMB), American Medical Massage Association (AMMA), or Federation of State Massage Therapy Boards (FSMTB) (ARSD 20:76:03:04).

The course must also comply with FSMTB's Course Category Policy (Board Action September 25, 2019).

Any or all of the required 8 hours of Continuing Education may be obtained electronically, in-person, or a mixture of both.

Please list each Continuing Education program you are claiming that was held between *October 1*, 2022 and *September 30*, 2024 in the spaces provided below. Please provide any additional course information on a separate sheet. If you were licensed during this Continuing Education cycle, please reference the proration chart on our website to see how many of the 8 hours you are required to complete.

You must include a copy of the certificate of completion for all listed courses.

Start Date	End Date	Title of Course	Provider/Approval Number (if applicable)	Hours Earned

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, 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 that 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	
For Office Use Only:	Date Received:	Ву
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