

3. COMMUNICATION

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 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:

Mailing Address:

Same as above

City: State: Zip:

Do you have another business address? Yes No

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

5. LEGAL QUESTIONS

(if you answer "yes" to any question, please provide a written explanation)

Have you been convicted of, or pled guilty or *nolo contendere* to, a felony, any crime involving or relating to the practice of massage, or any crime involving dishonesty or moral turpitude since your last renewal 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 that has not been reported to the Board? Yes No

Are you \$1,000 or more behind in child support payments? Yes No

6. OTHER LICENSES

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

Yes No ***If "yes", list active massage therapy licenses you currently have.***

| State | License Number | Expiration Date |
|-------|----------------|-----------------|
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7. PROOF OF MALPRACTICE OR PROFESSIONAL LIABILITY INSURANCE

Please attach verification of your insurance coverage Certificate of Insurance or Policy Declaration Page.

Malpractice or 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.

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 <i>(if applicable)</i> | Hours Earned |
|-------------------|-----------------|------------------------|--|---------------------|
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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: _____ *By* _____