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 2nd TEMPORARY PERMIT

Date of applicant's prior Temporary Permit was issued: _____/_____/_____

Please submit the following:

1. Please include one personal check, cashier's check, certified check or money order for a total of $125.00, includes:
   a. Application fee of $75.00
   b. Temporary permit fee of $50
2. Verification of any name change by applicant since prior permit date.
3. Copy of Malpractice or Professional Liability Insurance of at least $250,000, if expired since prior permit date.

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:

1. A verification letter from each state where licensed, along with a copy of license (See section 8. Other Licenses)

If issued, a Temporary Permit is valid for up to 90 days. A Temporary Permit expires after 90 days or in the event a regular license is issued.

Upon passage of a licensing exam, the Temporary Permit holder must complete an application for license – after temporary permit(s) or application for license and pay the applicable fees.

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

1. APPLICANT INFORMATION		
Full Name:		
first	middle	last
List any name(s) by which you have been known in the past including nicknames, maiden name etc. *(first, middle, last)*		
☐ I have been known by no other names	***If necessary provide additional names on a separate sheet***	
		☐ Maiden Name
Address		
City	State	Zip
Cell Phone ☐ None	Home Phone	☐ None
Date of Birth	Social Security Number	

For Office Use Only: *Date Received*: _____

Name of Applicant: _____

2. COMMUNICATION
The Board uses e-mail to communicate with licensees
E-mail Address:
Do you prefer to receive your permit mailed from the Board at your: ☐ Home ☐ Primary Business

3. EMPLOYMENT INFORMATION		
Do you have a business address? ☐ Yes ☐ No		
Name of 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.***		

4. PROOF OF MALPRACTICE OR PROFESSIONAL LIABILITY INSURANCE
Has your insurance been renewed since your 1st Temporary Permit? Yes ☐ No ☐ **If yes complete this section. If no proceed to next section.**
Please attach verification of your insurance coverage -- 1st page of Certificate of Insurance
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 permit, you are required by law to renew it.

Effective Date	Expiration Date	Carrier Name	Policy Number	Coverage Amount

5. MILITARY STATUS		
Are you the spouse of a member of the armed forces of the United States ☐ Yes ☐ No		
If Yes, was your spouse the subject of a military transfer to South Dakota?	☐ Yes	☐ No
If Yes, did you leave employment to accompany your spouse to South Dakota?	☐ Yes	☐ No

For Office Use Only: *Date Received*: _____

Name of Applicant: _____

6. 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.

7. OTHER LICENSES			
Have you ever held a license to practice massage therapy in another state or jurisdiction? YES ☐ NO ☐			
List all massage therapy licenses you have received after the date 1st Temporary Permit was issued:			
State or Jurisdiction	License Number	Date of Licensure	Expiration Date

If you have held a license, please attach a copy of the most current license.
A letter of license verification from the issuing state must be sent directly to the Board for all licenses listed, that have not already been sent for your Temporary Permit Application(s).

For Office Use Only: *Date Received*: _____

Name of Applicant: _____

8. 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)

9. 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 gender? ☐ Female ☐ Male	
What is your race? Please check all that apply.	
☐ Asian	☐ Hispanic or Latino
☐ American Indian or Alaska Native	☐ White or Caucasian
☐ Black or African American	☐ Other
☐ Native Hawaiian or Pacific Islander	

For Office Use Only: *Date Received*: _____

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, OMMISSIONS, 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 ADMINISTARTIVE 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: Check # _____Amount _____Dated_____

For Office Use Only: *Date Received*: _____