



# South Dakota Board of Massage Therapy

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website: [doh.sd.gov/boards/Massage/](http://doh.sd.gov/boards/Massage/)

## APPLICATION TO REACTIVATE 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. Reactivation 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 \$250,000.00 per occurrence - 1st page of certificate of insurance (See Section 6. Proof of liability insurance)
7. Proof of at least 8 hours of continuing education within the last two years

Attach Photo Here

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

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

1. APPLICANT INFORMATION			
License Number:			
Full Name:			
First	middle	last	
List any name(s) by which you have been known in the past including nicknames, maiden name etc. <i>(first, middle, last)</i>			
<input type="checkbox"/> I have been known by no other names <span style="float: right;"><b><i>If necessary provide additional names on a separate sheet</i></b></span>			
Maiden Name			<input type="checkbox"/> N/A
Address			
City		State	Zip
Cell Phone		<input type="checkbox"/> None	Home Phone <span style="float: right;"><input type="checkbox"/> None</span>
Date of Birth		Social Security Number	

2. MILITARY STATUS			
Are you or your spouse an active duty member of the armed forces of the United States		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, were you or your spouse the subject of a military transfer to South Dakota?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, are you or your spouse on full-time active duty status stationed in South Dakota		<input type="checkbox"/> Yes	<input type="checkbox"/> 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 reactivation fee.			

3. COMMUNICATION	
<b><i>The Board uses e-mail to communicate with licensees (Please print legibly)</i></b>	
E-mail	
Do you prefer to receive your license mailed from the Board at your: <span style="float: right;"><input type="checkbox"/> Home <input type="checkbox"/> Primary Business</span>	
Would you like to receive mailings about continuing education opportunities from third parties? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	

For Office Use Only:

Date Received: \_\_\_\_\_

Name of Applicant: \_\_\_\_\_

<b>4. EMPLOYMENT INFORMATION</b>			
Do you have a place of business where you perform massage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Business		Phone	
Physical Address			
Mailing Address			<input type="checkbox"/> Same as above
City	State	Zip	
<i>If you have another place of business where you perform massage, please provide additional contact information on a separate sheet.</i>			

<b>5. EDUCATION</b>			
Have you completed specific training in the practice of massage therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Facility(s) where completed:			
City	State	Date of Completion	
Name of Facility(s) where completed:			
City	State	Date of Completion	
<i>If you have attended another facility, please provide additional information on a separate sheet.</i>			

<b>6. PROOF OF MALPRACTICE OR PROFESSIONAL LIABILITY INSURANCE</b>
<b><i>Please attach verification of your insurance coverage – first page of Certificate of Insurance</i></b>
Malpractice of 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.

<b>7. OTHER LICENSES</b>			
Have you ever held a license to practice massage therapy in another state or jurisdiction?    YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b><i>List all massage therapy licenses you have ever held (active, inactive, lapsed, etc.). Do not include South Dakota.</i></b>			
State or Jurisdictions	License Number	Date of Licensure	Expiration Date
If you have additional licenses, please provide information on a separate sheet			

<b>8. ASSOCIATIONS</b>
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 yes, which association? <input type="checkbox"/> ABMP <input type="checkbox"/> AMTA <input type="checkbox"/> NAMT <input type="checkbox"/> Other (please list)

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9. LEGAL QUESTIONS	
<i>(if you answer YES to any question, please provide a written explanation)</i>	
<b>1.</b> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>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.</b>	
<b>2.</b> Is there any pending charge(s) against you with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>3.</b> Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>4.</b> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>5.</b> Have you had privileges revoked, reduced, or otherwise restricted at any healthcare provider entity? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>6.</b> Have you been treated for abuse or misuse of any alcohol or chemical substance? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>7.</b> Are you currently enrolled in an Alternative to Discipline Program? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>8.</b> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>9.</b> Do you currently owe child support arrearages in the sum of \$1,000 or more? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<b>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.</b>	

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"/> American Indian or Alaska Native	
<input type="checkbox"/> Black or African American	
<input type="checkbox"/> Native Hawaiian or Pacific Islander	
<input type="checkbox"/> Hispanic or Latino	
<input type="checkbox"/> White or Caucasian	
<input type="checkbox"/> Other	

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**12. CONTINUING EDUCATION VERIFICATION**

*Please attach verification of each course listed. You must also maintain a copy of the verification for your records for 5 years after the date of this licensure.*

The South Dakota Board of Massage Therapy requires that each licensed massage therapist accumulate 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.

See the course category policy identifying acceptable courses. The course category policy is located in Board Policies and Positions, pages 3 – 5, located on the home page of the website. <https://doh.sd.gov/boards/massage/>

Any or all of the required 8 hours of continuing education may be obtained electronically (online or by other electronic means).

Please list each continuing education program you are claiming in the spaces provide below.

Include a copy of the certificate of completion for all educational activities listed.

Start Date	End Date	Title of Educational Activity	NCBTMB Provider Number (if applicable)	Hours Earned

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, 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 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: \_\_\_\_\_