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 - AFTER TEMPORARY PERMIT(S)

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

a. If the issue date is greater than one year from application date, you are not eligible to complete this form. You must complete the Application for License and pay the applicable fees.
b. If issue date is one year or less from the postmarked date, please continue.

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 submit the following:

1. Application fee of $100.00
2. Licensing fee of $65 (refundable if application is denied)
3. Verification of any name change by applicant since prior permit date
4. Quality color photograph of applicant (from past six months)
5. Copy of Malpractice or Professional Liability Insurance of at least $250,000 per occurrence if expired since prior permit date.
6.

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

7. Proof of applicant's passing score on an accepted national competency exam. (See section 4. National Examination)
8. A verification letter from each state where licensed, along with a copy of license (See section 8. 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
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		

2. COMMUNICATION
The Board uses e-mail to communicate with licensees (Please print legibly)
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 opportunities from third parties? ☐ Yes ☐ No

For Office Use Only: *Date Received*: ___________________________

Name of Applicant:____

2. 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.***		

3. 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		

5. PROOF OF MALPRACTICE OR PROFESSIONAL LIABILITY INSURANCE				
Please attach verification of your insurance coverage (first 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. <u>The applicant must be a named insured of the coverage</u>				
Please provide the following information for your insurance coverage. If your insurance coverage expires during the term of your massage license, you are required by law to renew it.				
Effective Date	Expiration Date	Carrier Name	Policy Number	Coverage Amount

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.

For Office Use Only: *Date Received*: ____________________________

Name of Applicant:____

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 ever held (active, inactive, lapsed, etc.). Including South Dakota.			
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 or jurisdiction must be sent directly to the Board for all licenses listed, that have not already been sent for your Temporary Permit Application(s).			

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. 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

10. 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
☐ American Indian or Alaska Native
☐ Black or African American
☐ Native Hawaiian or Pacific Islander
☐ Hispanic or Latino
☐ White or Caucasian
☐ Other

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*: ____________________________