



# South Dakota Board of Massage Therapy

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

## APPLICATION FOR TEMPORARY PERMIT

Please submit the following with the completed application:

1. Please include one personal check, cashier's check, certified check or money order made payable to the State of South Dakota for \$125.00, includes:
  - a. Application fee of \$75.
  - b. Temporary Permit fee of \$50 (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 (legal document)
5. Quality color photograph of applicant (from past six months)
6. Copy of Malpractice or Professional Liability Insurance of at least \$250,000

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:

7. Proof of at least 500 hours of specific training in massage therapy by applicant (See section 4. Education)
  - a. Completed Verification of Education Form mailed or emailed directly to the board from the school
  - b. Official Transcript mailed or emailed directly to the board from the school
  - c. Document showing the school is approved by the State where school is located, or, accredited and accepted by the US Department of Education
8. 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. <i>(first, middle, last)</i>			
<input type="checkbox"/> I have been known by no other names		<b><i>If necessary provide additional names on a separate sheet</i></b>	
			<input type="checkbox"/> Maiden Name
Address			
City	State	Zip	
Cell Phone	<input type="checkbox"/> None	Home Phone	<input type="checkbox"/> None
Date of Birth	Social Security Number		

For Office Use Only:

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

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

<b>2. COMMUNICATION</b>		
<i>The Board uses e-mail to communicate with licensees (Please print legibly)</i>		
E-mail Address:		
Do you prefer to receive your permit mailed from the Board at your:	<input type="checkbox"/> Home	<input type="checkbox"/> Primary Business

<b>3. EMPLOYMENT INFORMATION</b>		
Do you have a business address?	<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:
Do you have another business address?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>If yes, please provide additional contact information on a separate sheet.</i>		

<b>4. EDUCATION</b>		
Have you completed at least 500 hours of 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
<i>A completed Verification of Education Form and official transcripts are to be <u>mailed or emailed</u> from the facility/school directly to the Board.</i>		
<i>The Verification of Education Form can be found on the website at <a href="http://doh.sd.gov/boards/massage/apps">doh.sd.gov/boards/massage/apps</a></i>		

<b>5. PROOF OF MALPRACTICE OR PROFESSIONAL LIABILITY INSURANCE</b>				
<i>Please attach verification of your insurance coverage Certificate of Insurance or Policy Declaration Page</i>				
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> (1st page of certificate of insurance)				
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

<b>6. MILITARY STATUS</b>		
Are you the spouse of a member of the armed forces of the United States	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, was your spouse the subject of a military transfer to South Dakota?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If Yes, did you leave employment to accompany your spouse to South Dakota?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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**7. 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.**

**8. 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 1<sup>st</sup> 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 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).***

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9. ASSOCIATIONS		
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)		

10. STATISTICAL INFORMATION			
<b><i>These questions are asked for statistical purposes. Your answers are optional.</i></b>			
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"/> Hispanic or Latino	
<input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> White or Caucasian	
<input type="checkbox"/> Black or African American		<input type="checkbox"/> Other	
<input type="checkbox"/> Native Hawaiian or Pacific Islander			

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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 ADMINISTRATIVE 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: \_\_\_\_\_