May 2011

Regular Mailing Address
State Board of Massage Therapy
P.O. Box 2649
Harrisburg, PA 17105-2649
Phone: 717-783-7155

Courier Delivery Address
State Board of Massage Therapy
2601 North Third Street
Harrisburg, PA 17110
email: RA-massagetherapy@state.pa.us

Application Instructions for:

MASSAGE THERAPIST LICENSURE BY EXAMINATION

All licenses expire on January 31, of odd-numbered years. You may not practice massage therapy unless you hold a current license. You may renew your license beginning 60 days before your current license expiration date.

CHECKLIST FOR APPLICANTS FOR LICENSURE BY EXAMINATION

___ Complete, sign and date the application.

___ Enclose a check or money order in the amount of $65.00. The check or money order should be made payable to the Commonwealth of Pennsylvania. The fee is not refundable. If all materials in support of your application are not received within 6 months of the date of your signature on the application, your application will not be processed and you will have to submit another application form and fee if you still wish to obtain a license.

____ Attach a copy of a legal form of identification, such as a driver's license, a current passport, or a valid state identification card. The copy should be submitted on an 8 ½ x 11 sheet of paper.

____ Attach the Certification of Good Moral Character form, filled out and signed by two individuals, who are not related to you, who have known you for at least six months.

____ An official Criminal History Record Check (CHRC) from the state agency for every state in which you have resided for the past 5 years. The report(s) must be dated within 6 months of the date of your application for licensure by examination. This report can be sent to you and forwarded to the Board with your application. For Pennyslvania CHRC, this can be done online at http://epatch.state.pa.us.

____a. If you have a criminal record, attach certified court documents related to the conviction(s) and a personal statement explaining the conviction(s) and what you have done since the conviction(s) that demonstrates that you are rehabilitated.

____ Attach a copy of your current Adult Basic CPR certification, including the expiration date of your CPR certification. The copy should be submitted on an 8 ½ x 11 sheet of paper. **Online CPR is not acceptable.**

____ Complete the top section of the "Verification of Massage Therapy Education" form and give the form to the Dean, Registrar or Chairperson of your Massage Therapy Program. The school must complete the bottom section and attach your transcripts. A qualifying program must be a minimum of 600 hours. **The school seal MUST be affixed where indicated and the ORIGINAL form returned by the school directly to the Board office in an official school envelope. The form must be completed AFTER you have received your certificate or degree: program completion may NOT be anticipated.**

____ You must request either FSMTB, PO Box 198748, Nashville TN 37219 (1-866-962-3926) or NCBTMB, 1901 S Meyers Road, Suite 240, Oakbrook Terrace, IL 60181 (1-800-296-0664), to have your exam scores released to the Board. This information must come directly from the testing agency to the Board.

____ If you are licensed in another state, request each state in which you now hold or ever held (active or inactive, current or expired) **a massage therapy license** to forward a "Letter of Good Standing" **directly** to the Board in a sealed official state board envelope.

NAME OR ADDRESS CHANGE:

If the name you are currently using on your application is different than the name you used on any of the other documents required to be submitted with your application, or if you change your name after you submit this application, send evidence of your name change within ten (10) days. For example, send a copy of marriage certificate or court order authorizing the name change.

If your address changes after you have submitted your application, notify the Board office in writing of your name, old address and new address. Mail this information to the Board office at the address shown above within ten (10) days.

OTHER INFORMATION:

Maintain a copy of all documents sent to the Board. Send your application materials to the Board at: State Board of Massage Therapy, PO Box 2649, Harrisburg, PA 17105-2649 OR (for courier delivery) 2601 North Third St, Harrisburg, PA 17110.

You may view the Massage Therapy Law and the regulations of the Board online at www.dos.state.pa.us/massagetherapy.

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MASSAGE THERAPIST LICENSURE by EXAMINATION APPLICATION

MAKE $65.00 FEE PAYABLE TO "COMMONWEALTH OF PENNSYLVANIA". NOT REFUNDABLE OR TRANSFERABLE. A PROCESSING FEE OF $20.00 WILL BE CHARGED FOR ANY CHECK OR MONEY ORDER RETURNED UNPAID BY YOUR BANK, REGARDLESS OF THE REASON FOR NON-PAYMENT.

NAME _____
Last First Middle Maiden/Other name used

ADDRESS _____
Street

_____
City State Zip Code

SOCIAL SECURITY #_____**BIRTHDATE** _____

PHONE NUMBER_____ **EMAIL ADDRESS**_____

EXAMINATION

You **must** have completed one of the following Board approved examination in massage therapy:

NCETM ____YES____ NO
NCETMB ____YES____ NO
MBLEx ____YES____ NO

EDUCATION

As required by Section 5 (a) (2), have you earned a high school diploma or equivalent? Yes____No____

Include in chronological order high school and all massage therapy schools attended.

INSTITUTION AND LOCATION (Include city and state)	**DATES ATTENDED**	**DIPLOMA, DEGREE OR CERTIFICATE AWARDED, If any**
H.S.	From To	
M.T.	From To	
	From To	
	From To	

ANSWER THE FOLLOWING: **If you answer "YES" to question(s) 2-5, give details on a separate 8 ½ X 11 sheet of paper AND provide a certified copy of all related official documentation.**	**YES**	**NO**
1. Have you previously taken the National Certification Examination for Therapeutic Massage (NCETM), the National Certification Examination for Therapeutic Massage and Bodywork (NCETMB) or the Massage and Bodywork Licensure Examination (MBLEx)? If **YES**, give the exam MONTH and YEAR and to which STATE the results were reported: _____		
2. Do you use or abuse alcohol, drugs, narcotics, chemicals or any other type of material that would impair your practice of massage therapy?		
3. Have you been convicted, found guilty or pleaded nolo contendere, or received probation without verdict or accelerated rehabilitative disposition (ARD) as to any felony or misdemeanor or do you have any criminal charges pending and unresolved in any state or jurisdiction? You are not required to disclose any criminal matter that has been expunged by order of a court.		
4. Have you ever possessed a license or other authorization to practice massage therapy or other occupation where you provide services to the public? If **YES**, list license type and state of issue: _____		
5. Have you ever withdrawn an application for a license or other authorization to practice massage therapy or any other occupation, denied or refused, or agreed not to reapply for a license in another state, territory or country? If **YES**, provide an explanation.		
6. Have you ever had a license or other authority to practice an occupation disciplined – including imposition of a fine, reprimand, suspension or revocation. If **YES**, name the license, state of issue and attach a copy of the disciplinary action: _____		

VERIFICATION

I verify that the statements in this application are true and correct to the best of my knowledge, information and belief. I understand that false statements are made subject the penalties of 18 PA C.S. Section 4904 relating to unsworn falsification to authorities and may result in the suspension or revocation of my licensure or registration**. I verify that I have read and am familiar with the provisions of the Pennsylvania Massage Therapy Law and regulations of the State Board of Massage Therapy (www.dos.state.pa.us/massagetherapy)**. I also verify that this form is in the original format as supplied by the Department of State and has not been altered or otherwise modified in any way. I am aware of the criminal penalties for tampering with public records or information pursuant to 18 PA C.S. Section 4911.

_____	_____	_____
Printed Name of Applicant	Signature of Applicant	Date

Note that disclosing your social security number on this application is mandatory in order for the State Board of Massage Therapy to comply with the requirements of the Federal Social Security Act pertaining to child support enforcement, as implemented in the Commonwealth of Pennsylvania at 23 Pa. C.S. § 4304.1(a). In order to enforce domestic child support orders, the Commonwealth's licensing boards must provide to the Department of Public Welfare information prescribed by DPW about the licensee, including the social security number. Additionally, disclosing the number is mandatory in order for this board to comply with the reporting requirements of the Federal Healthcare Integrity and Protection Data Bank. Reports to the HIPDB must include the licensee's social security number.

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Certification of Good Moral Character

To be completed by two individuals who have known you for at least six months. Do not use individuals who are related to you. **ORIGINAL SIGNATURES ARE REQUIRED**.

Name of Applicant:_____

I hereby certify that I have known the applicant for at least 6 months and that the applicant has good moral character. I recommend the applicant for a license to practice massage therapy in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for _____ year(s) _____ month(s).

SIGNATURE:_____ Date:_____

Print or type name as signed above:_____

State in which licensed: _____License Number:_____
(if applicable)

Name of Applicant:_____

I hereby certify that I have known the applicant for at least 6 months and that the applicant has good moral character. I recommend the applicant for a license to practice massage therapy in the Commonwealth of Pennsylvania.

I have been personally acquainted with the applicant for _____ year(s) _____ month(s).

SIGNATURE:_____ Date:_____

Print or type name as signed above:_____

State in which licensed: _____License Number:_____
(if applicable)

Return Completed Form to Applicant

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VERIFICATION OF MASSAGE THERAPY EDUCATION

Applicant for Licensure by **EXAMINATION**

Applicant: Complete (by typing/printing in blue/black ink) top section and send form to your Massage Therapy program to complete and attach your transcripts.

NAME_____

ADDRESS_____

SOCIAL SECURITY #_____ DATE OF BIRTH _____

This section to be completed by the Dean, Registrar, or Chairperson of the Massage Therapy program at the United States school which the applicant **COMPLETED. DO NOT complete this form in anticipation of program completion.**

I hereby certify that:

1) _____successfully completed a Massage
(Name of Applicant)

Therapy education program at _____on _____.
(School name) (Date)

2) The curriculum completed by Applicant equals or exceeds the curriculum requirements set forth in 49 Pa. Code § 20.11. **Hours completed**_____

3) The school is:

- ❑ A Pennsylvania Private Licensed School
- ❑ Operated within a regionally accredited College or University

_____
(Name of College or University)

- ❑ Approved by the MT Board or Department of Education of _____
(State)

_____ _____
(Printed name & Signature of Dean/Registrar/Chairperson of M. T. Program) (Date)

Name of Program_____

SEAL Name of Controlling Institution_____

Address _____

_____

SCHOOL SHALL RETURN AN ORIGINAL COMPLETED FORM DIRECTLY TO BOARD OFFICE IN AN OFFICIAL ENVELOPE AND ATTACH STUDENT TRANSCRIPTS. (DO NOT send a copy of this form or use envelope if provided by applicant)